Attachment 58

Iowa EMS Communications Plan

IOWA

EMERGENCY MEDICAL SERVICES

COMMUNICATIONS DIRECTORY

2002

Iowa Department of Public Health
Bureau of Emergency Medical Services
Lucas State Office Building
Des Moines, Iowa 50319
(515) 725-0326

www.idph.state.ia.us/ems

2002 IOWA EMERGENCY MEDICAL SERVICES COMMUNICATIONS DIRECTORY

The 2002 EMS Communications Directory contains the address, telephone number, and radio information for Iowa's hospitals. A map is included in the back of this directory listing the frequencies and tones generally used for various areas of the state.

Every effort has been made to insure that the information is accurate, but changes and errors are inevitable because of the many sources used in compiling this directory. If you find an error, please see the "2002 EMS Communications Directory - Correction Request" form located at the back of this directory.

Applying for a License to Operate on an EMS Frequency

The Federal Communications Commission regulates the usage of frequencies by EMS. It is the responsibility of all users of the communications equipment to insure that the usage is proper and that the station is properly licensed. Laws regarding usage are found in 47 CFR Part 90 which is available from the Government Bookstore at www.bookstore.gpo.gov.

All frequency coordinations for EMS is done by International Municipal Signal Association. The frequency must be approved by the Iowa Department of Public Health before forwarding the application for coordination pursuant to 47 CFR Part 90.27.

A copy of the completed FCC application must first be sent to:

Iowa Department of Public Health
805 East 12th Street
Vinton, IA 52349

The completed application, approval letter from the Department, and proper fees are then sent to:

Fire/EMS Frequency Coordination
PO Box 1513
Providence, RI 02901
Phone (401) 738-2220 Fax (401) 738-7336

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Albia	Monroe County Health Center 6580 165th St	(641) 932-7719	155.865	D 127.3	
Algona	Kossuth Regional Health Center 1515 South Phillips	(515) 295-2451	155.220 155.340	C 110.9 C 110.9	
Ames	Mary Greeley Medical Center 1111 Duff Ave	(515) 239-2155	155.340 155.400	A 82.5 A 82.5	1744 1744
Anamosa	Jones Regional Medical Center 104 Broadway Place	(319) 462-6131	155.220	G 192.8	1024
Atlantic	Cass County Memorial Hospital 1501 East Tenth Street	(712) 243-3250	155.340	B 94.8	1800922
Audubon	Audubon County Memorial Hospital 515 Pacific	(712) 563-2611	155.340	B 94.8	
Belmond	Belmond Medical Center 403 First Street SE	(641) 444-3223	155.205 155.340	G 192.8 G 192.8	522 522
Bloomfield	Davis County Hospital 507 North Madison	(641) 664-2145	155.340	H 210.7	
Boone	Boone County Hospital 1015 Union Street	(515) 432-3140	155.340	A 82.5	1742
Britt	Hancock County Memorial Hospital 532 First Street NW	(641) 843-3801	155.340	C 110.9	

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Carroll	St. Anthony Regional Hospital 406 East Anthony Street	(712) 792-3581	155.160 155.340	E 146.2 E 146.2	1800822 1800822
Cedar Falls	Sartori Memorial Hospital 515 College	(319) 268-3000	155.175 155.340	B 94.8 B 94.8	1924 1924
Cedar Rapids	*Services not normally transporting patients to Cedar Rapids may wish to call "C-Med"*				
			155.220 *155.280* *155.340*	*G 192.8* *G 192.8* *G 192.8*	
	Mercy Medical Center 701 Tenth Street SE	(319) 398-6482	155.220 155.280 155.340	G 192.8 G 192.8 G 192.8	1026 1026 1026
	St. Luke's Methodist Hospital 1026 A Avenue NE	(319) 369-7105	155.220 155.280 155.340	G 192.8 G 192.8 G 192.8	1027 1027 1027
Centerville	Mercy Medical Center - Centerville 1 Street / St Joseph's Drive	(641) 437-3440	155.220 155.340	B 94.8	
Chariton	Lucas County Memorial Hospital 1200 North Seventh Street	(641) 774-3211	155.340	B 94.8	
Charles City	Floyd County Memorial Hospital 800 11th Street	(641) 228-6830	155.220 155.340 155.400	C 110.9 C 110.9	 1624
Cherokee	Sioux Valley Memorial Hospital 300 Sioux Valley Drive	(712) 225-5101	155.220 155.340	D 127.3 D 127.3	1354 1354

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Clarinda	Clarinda Regional Health Center 17th and Wells	(712) 542-2176	155.235 155.340	H 210.7 H 210.7	1253 1253
Clarion	Community Memorial Hospital 1316 South Main Street	(515) 532-2811	155.205 155.340	G 192.8	
Clinton	Mercy Medical Center - Clinton 1410 N 4th Street	(563) 244-5555	155.205 155.340	C 110.9 C 110.9	1032 1032
Corning	Alegent Health - Mercy Hospital Rosary Drive	(515) 322-3121	155.340		
Corydon	Wayne County Hospital 417 South East	(515) 872-2260	155.220 155.340	B 94.8 B 94.8	
Council Bluffs	Alegent Mercy Hospital 800 Mercy Drive	(712) 328-5573	155.340		180222
	Jennie Edmundson Mem. Hospital 933 East Pierce	(712) 328-6000	155.340		180222
Cresco	Howard County Reg Health Svcs 235 Eighth Avenue West	(563) 547-2101	155.235 155.340	A 82.5 A 82.5	0117 0117
Creston	Greater Community Hospital 1700 West Townline Street	(641) 782-7091	155.205 155.340	G 192.8 G 192.8	

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Davenport	Trinity Medical Center North 1111 W Kimberly Road	(563) 445-4020	155.340	G 192.8	1805022
	Genesis Medical Center - West 1401 West Central Park Ave	(563) 421-1100	155.340	G 192.8	1802822
	Genesis Medical Center - East 1227 East Rusholme	(563) 421-7681	155.340	G 192.8	1802922
Decorah	Winneshiek County Mem. Hospital 901 Montgomery Street	(563) 382-2911	155.235 155.340	F 167.9 F 167.9	1805922 1805922
Denison	Crawford County Memorial Hospital 2020 First Avenue South	(712) 263-5021	155.340	H 210.7	1442
Des Moines	*Services not normally transporting patients to Des Moines may wish to call "C-Med"*				
			155.220 *155.340* *155.400*	*A 82.5* *A 82.5* *A 82.5*	
	Broadlawns Medical Center 1801 Hickman Road	(515) 282-9749	155.220	A 82.5	1722
	Mercy – Capitol 600 East Twelfth Street	(515) 643-0011	155.220 155.340	A 82.5 A 82.5	1723 1723
	Iowa Lutheran Hospital 700 East University	(515) 263-5120	155.220 155.340	A 82.5 A 82.5	1724 1724
	Iowa Methodist Medical Center 1200 Pleasant Street	(515) 241-6423	155.220 155.340	A 82.5 A 82.5	1725 1725

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Des Moines (continued)	Mercy Hospital Medical Center 1111 Sixth Ave	(515) 247-3173	155.220 155.340	A 82.5 A 82.5	1726 1726
	Veterans Hospital 30th and Euclid	(515) 966-5915	155.220	A 82.5	1728
DeWitt	DeWitt Community Hospital 1118 Eleventh Street	(563) 659-4200	155.205 155.340	C 110.9 H 210.7	1034
Dubuque	Finley Hospital 350 North Grandview Avenue	(563) 589-2460	155.205 155.340	B 94.8 B 94.8	1909522 1909522
	Mercy Medical Center 250 Mercy Drive	(563) 589-9666	155.205 155.340	H 210.7 H 210.7	1909922 1909922
Dyersville	Mercy Medical Center 1111 Third Street SW	(563) 875-2911	155.340	C 110.9	1039
Elkader	Central Community Hospital 901 Davidson Street	(563) 245-7000	155.340	A 82.5	0113
Emmetsburg	Palo Alto County Health System 3201 First Street	(712) 852-5500	155.340 155.400	D 127.3 D 127.3	1346 1346
Estherville	Avera Holy Family Health 826 North Eighth Street	(712) 362-2631	155.340 155.400	A 82.5 A 82.5	1333 1333

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Fairfield	Jefferson County Hospital 400 Highland Ave	(641) 472-4111	155.205 155.340	G 192.8 G 192.8	1843 1843
Fort Dodge	Trinity Medical Center 802 Kenyon Road	(515) 573-3101	155.205 155.340	G 192.8 G 192.8	
Fort Madison	Fort Madison Community Hospital 2210 Avenue H	(319) 372-6530	155.235 155.340	C 110.9 C 110.9	1853 1853
Greenfield	Adair County Memorial Hospital 609 SE Kent	(641) 743-2123	155.160 155.340	G 192.8 G 192.8	 1232
Grinnell	Grinnell Regional Medical Center 210 4th Ave	(641) 236-7511	155.340	G 192.8	1747
Grundy Center	Grundy County Memorial Hospital 201 East J Ave	(319) 824-5421	155.340	B 94.8	0719
Guthrie Center	Guthrie County Hospital 710 North Twelfth Street	(641) 747-2201	155.340	D 127.3	1804822
Guttenberg	Guttenberg Municipal Hospital Second and Main	(563) 252-1121	155.340	A 82.5	0115
Hamburg	Grape Community Hospital 2959 US Highway 275	(712) 382-1515	155.340	A 82.5	
Hampton	Franklin General Hospital 1720 Central Avenue East	(641) 456-5000	155.340	D 127.3	1906722

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Harlan	Myrtue Memorial Hospital 1213 Garfield Avenue	(712) 755-5161	155.340	A 82.5	1804022
Hawarden	Hawarden Community Hospital 1111 Eleventh Street	(712) 551-3100	155.340 155.400	A 82.5 A 82.5	1347 1347
Humboldt	Humboldt County Mem Hospital 1000 North Fifteenth St.	(515) 332-4200	155.205 155.340	G 192.8 G 192.8	
Ida Grove	Horn Memorial Hospital 701 East Second Street	(712) 364-3311	155.220 155.340	D 127.3 D 127.3	
Independence	People's Memorial Hospital 1600 1st Street	(319) 334-6071	155.340	B 94.8	0717
Iowa City	*Services not normally transporting patients to Iowa City may wish to call "C-Med" or "University Dispatch"*		*155.340*	*G 192.8*	
	Mercy – Iowa City 500 East Market Street	(319) 339-3600	155.340	G 192.8	1023
	Univ. of Iowa Hospitals & Clinics 200 Hawkins Drive	(319) 353-8833	155.340	G 192.8	2233
	VA Medical Center Highway 6 West	(319) 339-7142	155.340	G 192.8	0581

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Iowa Falls	Ellsworth Municipal Hospital 110 Rocksylvania Avenue	(641) 648-4631	155.160 155.340	D 127.3 D 127.3	
Jefferson	Greene County Medical Center 1000 West Lincolnway	(515) 386-2114	155.340	G 192.8	1804722
Keokuk	Keokuk Area Hospital 1600 Morgan Street	(319) 524-7150	159.285 155.340	 C 110.9	 1862
Keosauqua	Van Buren County Hospital Highway 1 North	(319) 293-3171	155.205 155.340	B 94.8 E 146.2	 1855
Knoxville	Knoxville Area Community Hospital 1002 South Lincoln	(641) 842-1420	155.340 155.400		
Lake City	Stewart Memorial Comm. Hospital 1301 West Main	(712) 464-3171	155.340	B 94.8	
LeMars	Floyd Valley Hospital 714 Lincoln Street NE	(712) 546-7871	155.220 155.340	D 127.3 D 127.3	1357 1357
Leon	Decatur County Hospital 1203 N Church Street	(641) 446-4871	155.205 155.340	G 192.8	 1554
Manchester	Regional Health Center of NE Iowa 709 West Main	(563) 927-3232	155.220	G 192.8	1020
Manning	Manning Regional Healthcare Ctr 410 Main Street	(712) 653-2072	155.340????	F 167.9	

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Maquoketa	Jackson County Public Hospital 700 West Grove Street	(563) 652-2474	155.340	E 146.2	1805622
Marengo	Marengo Memorial Hospital 300 West May Street	(319) 642-5543	155.220 155.385	G 192.8 G 192.8	1022 1022
Marshalltown	Marshalltown Med & Surg Center 3 South Fourth Avenue	(641) 754-5040	155.160 155.340	A 82.5 A 82.5	0613 0613
Mason City	Mercy Medical Center – North Iowa 1000 4th Street SW	(641) 422-7000	155.220 155.340 155.400	C 110.9 C 110.9	
Missouri Valley	Alegent Health – Comm Mem Hosp 631 North Eighth Street	(712) 642-2784	155.235 155.340	C 110.9 C 110.9	1234 1234
Mount Ayr	Ringgold County Hospital 211 Shellway Drive	(641) 464-3226	155.340	G 192.8	
Mount Pleasant	Henry County Health Center 407 South white	(319) 385-3141	155.235 155.340	E 146.2 H 210.7	1842
Muscatine	Unity Health System 1518 Mulberry Ave	(563) 264-9100	155.340 155.400	G 192.8 H 210.7	1834
Nevada	Story County Medical Center 630 Sixth Street	(515) 382-7000	155.340 155.400	A 82.5 A 82.5	1745 1745
New Hampton	Mercy Med Center – New Hampton 308 North Maple Ave	(641) 394-4121	155.175 155.340	B 94.8 B 94.8	1942 1942

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Newton	Skiff Medical Center 204 N Fourth Avenue East	(641) 791-4300	155.340 155.400	A 82.5 A 82.5	1755 1755
Oelwein	Mercy Hospital / Franciscan Sisters 201 Eighth Avenue SE	(319) 283-6000	155.340	A 82.5	0115
Onawa	Burgess Health Center 1600 Diamond Street	(712) 423-2311	155.220 155.340	D 127.3 G 192.8	1443
Orange City	Orange City Health System 400 Central Ave NW	(712) 737-4984	155.340 155.400	A 82.5 A 82.5	1348 1348
Osage	Mitchell County Reg. Health Center 616 North Eighth Street	(641) 732-6000	155.220 155.340	C 110.9 C 110.9	
Osceola	Clarke County Hospital 800 South Filmore	(641) 342-2184	155.205 155.340	G 192.8 G 192.8	 1542
Oskaloosa	Mahaska Hospital 1229 C Avenue East	(641) 672-3100	155.205 155.340	B 94.8 G 192.8	1833
Ottumwa	Ottumwa Regional Health Center 1001 East Pennsylvania Ave	(641) 682-7511	155.205 155.340	B 94.8 G 192.8	1844
Pella	Pella Community Hospital 404 Jefferson Street	(641) 628-6640	155.340 155.400	 A 82.5	 1758
Perry	Dallas County Hospital 610 10th Street	(515) 465-7660	155.340 155.400	A 82.5 A 82.5	1753 1753

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Pocahontas	Pocahontas Community Hospital 606 Northwest Seventh	(712) 335-3501	155.205 155.220 155.235	H 210.7	
Primghar	Baum-Harmon Mercy 255 North Welch Ave	(712) 757-2300	155.340 155.400	A 82.5 A 82.5	1344 1344
Red Oak	Montgomery County Mem. Hospital 2301 Eastern Avenue	(712) 623-7000	155.235 155.340	C 110.9 C 110.9	1243 1243
Rock Rapids	Merrill Pioneer Comm. Hospital 801 South Greene Street	(712) 472-2591	155.340 155.400	A 82.5 A 82.5	1334 1334
Rock Valley	Hegg Memorial Hospital 1202 21st Avenue	(712) 476-8000	155.340 155.400	A 82.5 A 82.5	1349 1349
Sac City	Loring Hospital 211 Highland Avenue	(712) 662-7105	155.220 155.340	C 110.9 C 110.9	
Sheldon	Northwest Iowa Health Center 118 North Seventh	(712) 324-5041	155.340 155.400	A 82.5 A 82.5	 1345
Shenandoah	Shenandoah Medical Center 300 Pershing Avenue	(712) 246-1230	155.340	C 110.9	1323
Sibley	Osceola Community Hospital Ninth Avenue North	(712) 754-2574	155.340 155.400	A 82.5 A 82.5	1335 1335
Sigourney	Keokuk County Health Center 1312 South Stuart	(641) 622-2720	155.205 155.340	B 94.8 B 94.8	1832 1832

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Sioux Center	Community Hosp. & Health Center 605 South Main Avenue	(712) 722-1271	155.340 155.400	A 82.5 A 82.5	1340 1340
Sioux City	*Services not normally transporting patients to Sioux City may wish to call "Siouxland Dispatch"*				
			155.160 *155.220* *155.340*	*D 127.3* *D 127.3* *D 127.3*	
	St. Luke's Regional Med. Center 2720 Stone Park Blvd.	(712) 279-3500	155.220 155.340	D 127.3 D 127.3	1424 1424
	Mercy Medical Center – Sioux City 801 Fifth Street	(712) 279-2010	155.220 155.340	D 127.3 D 127.3	1422 1422
Spencer	Spencer Hospital 1200 1st Ave East	(712) 264-6198	155.340 155.400	A 82.5 A 82.5	1342 1342
Spirit Lake	Dickinson County Memorial Hospital Highway 71 South	(712) 336-1230	155.340 155.400	A 82.5 A 82.5	
Storm Lake	Buena Vista Regional Medical Center 1525 West Fifth Street	(712) 732-4030	155.340 155.400	A 82.5 A 82.5	
Washington	Washington County Hospital 400 East Polk Street	(319) 653-5481	155.220 155.340	G 192.8 G 192.8	1028 1028
Sumner	Community Memorial Hospital 909 West First Street	(563) 578-3275	155.340	B 94.8	0715
Vinton	Virginia Gay Hospital 502 North Ninth Avenue	(319) 472-6200	155.220 155.340	G 192.8 G 192.8	1029 1029

City	*Hospital Information*	*Phone #*	*Frequency*	*Tone*	*Dial #*
Waterloo	Allen Memorial Hospital 1825 Logan Avenue	(319) 235-3697	155.175 155.340	B 94.8 B 94.8	0711 0711
	Covenant Medical Center 3421 West Ninth Street	(319) 272-7050	155.175 155.340	B 94.8 B 94.8	0714 0714
Waukon	Veterans Memorial Hospital 400 1st Street SE	(563) 568-3411	155.340	A 82.5	0112
Waverly	Waverly Municipal Hospital 312 Ninth Street SW	(319) 352-4120	155.340	B 94.8	0716
Webster City	Hamilton County Public Hospital 800 Ohio Street	(515) 832-9400	155.220 155.340	G 192.8 F 167.9	
West Burlington	Great River Medical Center 1221 South Gear Ave	(319) 768-1000	155.235 155.340	H 210.7 H 210.7	 1822
West Union	Palmer Lutheran Health Center 112 Jefferson	(563) 422-3811	155.340	A 82.5	1946
Winterset	Madison County Memorial Hospital 300 Hutchings	(515) 462-2373	155.340 155.400	A 82.5 A 82.5	1756 1756

2002 Iowa EMS Communications Directory
Correction Request

This form should be used to correct errors or make changes to the 2002 EMS Communications Directory. If you wish to make any changes, please fill out the form completely and return to:

Iowa Department of Public Health
805 East 12th Street
Vinton, IA 52349
FAX (319) 472-5642
Or Email Tboeckma@health.state.ia.us

HOSPITAL NAME

ADDRESS

CITY

TELEPHONE ___-___-____

CONTACT PERSON

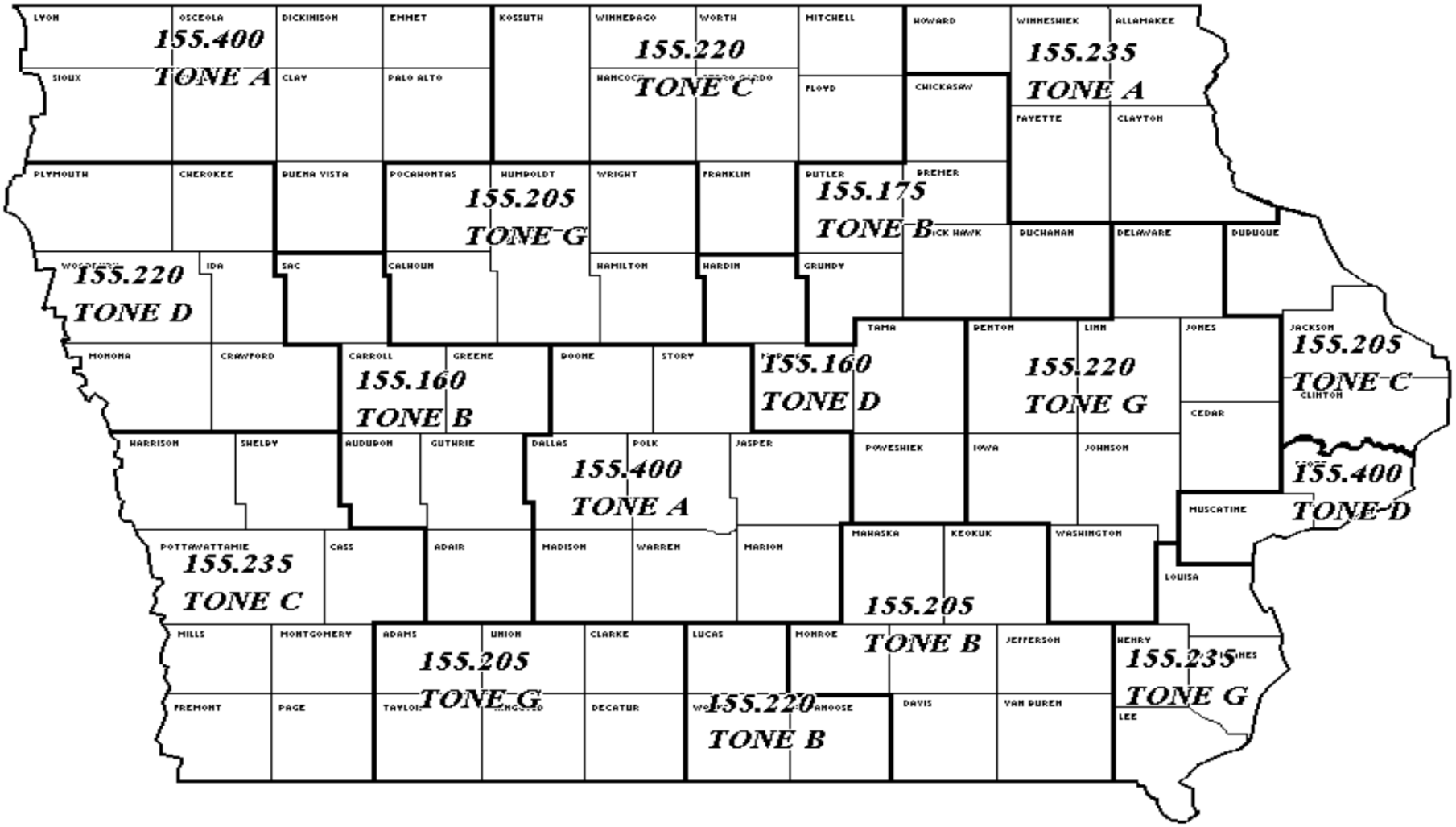
PHONE ___-___-____

NEW RADIO INFORMATION

FREQUENCY	TONE	DIAL
___.___	___.___	_____
___.___	___.___	_____
___.___	___.___	_____

Iowa Department of Public Health
Bureau of Emergency Medical Services

Frequency and Tone Code Assignments



Attachment 59

System Development Grant Awards

FY15 EMS System Development Grant Awards (after new additional funding amentments)

Awardee	Grant Award
Adams County Board of Health	$5,062
Appanoose County Board of Supervisors	$7,228
Benton County Board of Health	$12,478
Black Hawk County Board of Health	$12,075
Boone County Board of Supervisors	$9,717
Bremer County Board of Supervisors	$9,519
Buena Vista County Board of Supervisors	$8,223
Butler County Board of Health	$10,447
Calhoun County Board of Health	$8,749
Carroll County Board of Supervisors	$8,926
Cedar County Board of Supervisors	$10,421
Cerro Gordo County Board of Supervisors	$8,308
Cherokee County Board of Supervisors	$7,587
Chickasaw County Board of Supervisors	$7,698
Clay County Board of Health	$6,921
Clayton County Board of Health	$12,954
Clinton County Board of Supervisors	$11,591
Crawford County Board of Health	$9,375
Dallas County Board of Supervisors	$12,090
Davis County Board of Supervisors	$7,273
Decatur County Board of Supervisors	$7,495
Delaware County Board of Health	$9,492
Des Moines County Board of Health	$7,838
Dickinson County Board of Health	$4,884
Dubuque County Board of Supervisors	$13,614
Emmet County Board of Supervisors	$4,794
Fayette County Board of Supervisors	$11,686
Floyd County Board of Health	$7,572
Franklin County Board of Supervisors	$7,320
Greene County Board of Supervisors	$6,736
Hamilton County Board of Health	$7,809
Hancock County Board of Supervisors	$7,922
Hardin County Board of Supervisors	$9,875
Harrison County Board of Supervisors	$10,262
Henry County Board of Health	$8,077
Howard County Board of Health	$6,089
Humboldt County Board of Supervisors	$5,455
Ida County Board of Supervisors	$6,391
Iowa County Board of Supervisors	$10,603
Jackson County Board of Supervisors	$9,197
Jasper County Board of Supervisors	$13,824
Jefferson County Board of Health	$6,043
Johnson County Board of Supervisors	$14,783

Jones County Board of Health	$8,933
Keokuk County Board of Supervisors	$8,921
Kossuth County Board of Supervisors	$12,003
Lee County Board of Supervisors	$10,040
Linn County Board of Supervisors	$11,529
Louisa County Board of Health	$7,844
Lucas County Board of Supervisors	$5,324
Lyon County Board of Supervisors	$9,131
Mahaska County Board of Supervisors	$8,417
Marion County Board of Supervisors	$9,747
Marshall County Board of Supervisors	$9,570
Mills County Board of Health	$6,954
Mitchell County Board of Health	$6,542
Monroe County Board of Health	$5,140
Muscatine County Board of Supervisors	$8,155
O'Brien County Board of Supervisors	$8,560
Osceola County Board of Supervisors	$4,756
Palo Alto County Board of Supervisors	$6,914
Plymouth County Board of Health	$12,850
Pocahontas County Board of Supervisors	$7,884
Polk County Board of Supervisors	$12,888
Pottawattamie Board of Supervisors	$16,699
Poweshiek County Board of Health	$8,345
Sac County Board of Supervisors	$8,963
Scott County Board of Health	$12,619
Shelby County Board of Supervisors	$7,731
Sioux County Board of Supervisors	$12,617
Story County Board of Supervisors	$12,186
Tama County Board of Health	$10,681
Taylor County Board of Health	$6,813
Union County Board of Supervisors	$5,187
Van Buren County Board of Supervisors	$6,819
Wapello County Board of Supervisors	$7,618
Warren County Board of Health	$10,856
Washington County Board of Supervisors	$9,789
Wayne County Board of Health	$6,757
Webster County Board of Health	$11,219
Winnebago County Board of Supervisors	$6,144
Winneshiek County Board of Health	$10,660
Woodbury County Board of Supervisors	$13,431
Worth County Board of Supervisors	$6,176
Wright County Board of Supervisors	$7,711
Totals:	$765,526

Attachment 60

System Standards Self-Assessment Tool

Instructions for completion of the Iowa EMS System Standards Self-Assessment

Each recipient of the EMS Systems Standards grant must complete and submit a self-assessment of their county services based on the September 2010 Iowa EMS Systems Standards document (www.idph.state.ia.us/ems/ems_system_standards.asp). The self-assessment must be completed and submitted in the county's IDPH SharePoint service contract site by the date identifed in the current contract. Failure to submit the completed Self Assessment by the due date will result in the withholding of 5 percent of the recipient'sgrant award.

Under the tab labeled Assessment you will find the 52 Iowa EMS System Standards and their associated measurement examples. For each standard identify the status of the county's EMS system by selecting one of the provided choices of completed, in-progress, or not started. The selection should be based on the compiled measurement of all authorized EMS agencies being represented by the association. As an example for standard 1.06 if the association represents 3 services and 2 of the 3 services have a policy on the provision of ALS care and the third service has not started or completed the policy for their service. You would place an "X" in the column for "In-Progress" (see below).

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.06	The EMS system shall have a provision for ALS care.	Policy on provision for ALS.		X				

For each standard status you select either in-progress or not started, please select one or more of the choices of Fiscal, Time, or Personnel for Implementation Challenges. As an example continuing to use standard 1.06 let's assume that the third EMS agency in the county had not completed the policy on ALS provision stating they do not have the time or personnel, you would select both the Time and Personnel

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.06	The EMS system shall have a provision for ALS care.	Policy on provision for ALS.		X			X	X

NOTE: Do not include the measurement documents with this assessment. Maintain all suggested measurement documents at your location. Please contact Stephen Poole at 515-281-4054 or by email at stephen.poole@idph.iowa.gov with any questions regarding the completion of this self assessment.

1 - System Organization and Management									
Number	Standard	Measurement	Status			Implementation Challenges			
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel	
1.01	Each county shall make provisions for emergency medical services treatment and transport for all within the county, to meet Iowa EMS Systems Standards. Each county shall be responsible for the approval of services within their EMS system based on a needs assessment.	Declaration from County Board of Supervisors or governing body.							
		Organizational chart							
		Policy on how services are approved.							
		Needs assessment.							

Number	Standard	Measurement	Status			Implementation Challenges			
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel	
1.02	The EMS system shall have a written vision and mission statement and will meet at least annually to engage in strategic	Vision statement							
		Mission statement							

	planning. The EMS system shall have a formal organization chart that identifies who is responsible for implementing the Iowa EMS system standards.	Minutes of annual strategic planning meeting including attendance roster.						
		Organizational chart						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.03	The EMS system shall have a mechanism to seek and obtain appropriate consumer and health care provider input.	Board member from public and/or survey tool for public feedback.						
		Board member from health care provider and/or survey tool for health care provider feedback.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

1.04	The EMS system shall have an active medical director or active Medical Director system. Systems with multiple medical directors shall form a medical advisory council to support the system medical director.	Medical Director form for system or letter of agreement forming a council.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.04a	Each EMS system shall develop written medical direction policies, procedures, and/or protocols for all transporting/non-transporting EMS services including, but not limited to: triage; treatment; medical dispatch protocols; transport/tiered response/provision of ALS care; on-scene treatment times; transfer of emergency patients (i.e. stroke, mi, trauma); standing orders; hospital contact; and on-scene physicians and other medical personnel.	At Minimum the Iowa EMS Protocol with notations for any deviations.						
		Protocols are signed and dated annually.						
		Documented training on the protocols.						
		Policy that addresses additional areas not addressed by Protocol.						

Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.04b	Each EMS system shall develop and utilize a medical control plan that shall have on-line medical direction available that is provided by a physician or physician designee or supervising physician. The plan shall also identify the role of hospitals, alternate medical control and the roles, responsibilities, and relationships of out-of-hospital providers.	Documentation of the primary medical control plan with hospital or hospitals identified.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.04c	The EMS system, in conjunction with the county medical examiner, shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.	Policy reguarding determination of death.						
		Policy that describes the process for physician determination of death and notification procedures.						

Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.04d	The EMS system shall ensure that providers have a mechanism for reporting child abuse, and dependant adult abuse.	Policy for notification.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.04e	The EMS medical direction, in conjunction with transferring facilities, shall establish policy and procedures for out of hospital medical personnel during inter-facility transfers.	Medical protocols or a separate policy identifying who is to be called for medical direction during inter-facility transfer.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.05	The EMS system shall develop an EMS System Plan, based on community need and utilization of appropriate resources, and shall submit it to the EMS Bureau. The plan shall: assess how the current system meets	Documentation of System Assessment.						
		Examples of Special Needs population.						

	these guidelines; identify system needs for patients within each of the targeted clinical categories/special populations; provide a methodology and timeline for meeting these needs; have a continuous quality improvement and evaluation process that is approved by the EMS system; provide for review and monitoring of EMS system operations; provide for an annual update to the EMS System Plan and submit the plan to the EMS Bureau. The update shall identify progress made in plan implementation and changes to the planned system design.	Documentation of how special needs populations identified.						
		CQI Policy						
		Documentation of review and monitoring of EMS System operation.						
		Documentation of Annual Update						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.06	The EMS system shall have a provision for ALS care.	Policy on provision for ALS.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

1.07	The EMS system shall develop in coordination with county EMA a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.	Documentation of annual Inventory						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.08	The EMS system shall ensure that system participants conform to their assigned EMS system roles and responsibilities.	Documentation of compliance of each system participant.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

1.09	The EMS system shall develop policies and procedures that implement the Iowa EMS system standards. The system shall ensure that the manual is available to all EMS system providers (including public safety agencies, ambulance services, non-transport services, air-medical services, and hospitals) within the system. The EMS system shall have a mechanism to review, monitor and ensure compliance with system policies at least annually.	Manual and an annual review signature page with System Coordinator/Designee and Medical Director Signature and dates						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
1.10	The EMS system shall identify funding mechanisms that are sufficient to ensure its continued operation and shall maximize use of its fiscal resources.	Documentation of how the system is funded to maintain operation.						

2 - Staffing and Training								
Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

2.01	The EMS system shall, at least annually, assess staffing and training needs.	Annual assessment report						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.02	The EMS system shall have mechanisms to assure certification.	Application (System Registry) is current & complete						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.02a	The EMS system shall have a process for providers to identify and notify the Bureau of EMS, as required by rule, of occurrences that impact EMS certification.	Policy that describes process						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.02b	Services within the EMS system shall have a plan in place to credential personnel as applicable to EMS certification levels and	Skill requirements addressed in CQI policy						

	local protocol as authorized by the medical director.	Documentation of compliance.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.03	Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) shall be trained and/or certified using an approved program.	Roster of personnel, training date(s) and program utilized.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.04	The EMS System shall ensure at least one person on each non-transporting EMS response shall be a currently certified EMS provider. Public safety agencies and industrial first-aid teams shall be utilized in accordance with EMS system policies.	Documentation on PCR of certified provider(s).						
		Current list of public safety agencies and/or industrial first-aid teams with contact name and contact information updated annually						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.05	The EMS system shall ensure that all transporting units meet state personnel minimum staffing requirements.	Documentation of all staff on Patient Care Report (PCR)						
		System response policy						
		Contingency plan						
		Transport agreement						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
2.06	The EMS system shall ensure all hospital/alternative base station personnel who provide medical direction to out of hospital personnel shall be knowledgeable about EMS system policies and procedures.	Policy and Procedure						
		Documentation of training to include date and roster						

3 - Communications				
Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.01	The EMS system shall develop a plan to coordinate EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles; non-transporting agencies; and system participants.	Plan to coordinate EMS communications.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.02	The EMS system shall ensure system participants have two-way communications equipment that complies with the EMS communications plan and that provides for dispatch and ambulance-to-hospital communication.	Documentation of compliance with the EMS Communications Plan.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

3.02a	The EMS system shall ensure all hospitals within the EMS system shall (where physically possible) have the ability to communicate with each other by two-way communications according to the EMS plan.	Documentation of compliance						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.02b	The EMS system shall ensure system participants involved in inter-facility transfers have the ability to communicate with both the sending and receiving facilities.	Documentation of compliance						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.03	The EMS system shall ensure all emergency medical transport vehicles, where physically possible (based on geography and technology), shall have the ability to communicate with a single dispatch center or disaster communications command post.	Documentation of compliance with EMS communications plan.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.03a	The EMS system shall review, at least annually, communications linkages (inter-operability) among providers (out of hospital and hospital) in its jurisdiction and recommend needed changes for their capability to provide service in the event of multi-casualty incidents and disasters.	Documentation of annual review.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.03b	The EMS system shall have a functionally integrated dispatch with system-wide emergency management coordination, using standardized communications frequencies.	Documentation of compliance.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

3.03c	The EMS system may establish an emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.	Policy for system use and training.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.04	The EMS system shall seek to have an active member appointed to the county 911 commission in order to participate in ongoing planning and coordination of the enhanced 9-1-1 system.	Demonstration of active member appointed to the commission or documentation of efforts to accomplish this standard.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
3.05	The EMS system shall be involved in public education regarding system access.	Documentation of educational plans, activities, and ongoing goals.						

4 - Response & Transportation				
Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
4.01	The EMS system shall, in coordination with neighboring EMS systems, determine the emergency medical service response areas, to ensure the most appropriate response.	Map identifying system response to service area						
		Documentation of criteria used to ensure an appropriate response						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
4.02	The EMS system shall monitor compliance with appropriate code, rules, policies and procedures.	Documentation of compliance with appropriate response, transport, and destination policies.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
4.03	The EMS system shall have contingency plans and assure the development of mutual aid	Contingency plan						

	agreements to provide for emergent and non-emergent response during increased system volume.	Transport Agreements						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

4.04	Each EMS system shall adopt the following standards for emergent response. These standards shall take into account the total time from dispatch to arrival of the responding unit at the scene, including all dispatch intervals and driving time. Emergency medical service areas (response zones) shall be designated so that, for eighty percent of emergent responses: The response time for first responders does not exceed: 1.Urban-5 minutes 2.Rural-15 minutes 3.Wilderness-as quickly as possible The response time for an ambulance (not functioning as a first responder) does not exceed: 1. Urban-8 minutes 2. Rural-20 minutes 3. Wilderness-as quickly as possible The response time for advanced life support does not exceed: 1. Urban-8 minutes 2. Rural-20 minutes	Response Data that shows compliance.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

4.05	The EMS system shall have a process for identifying specialty air-medical transport services and shall develop policies and procedures regarding: • Requesting of air-medical services • Determination of patient destination • Orientation of pilots and medical flight crews to the EMS system • Addressing and resolving formal complaints	List of Air Services utilized						
		Policy and Procedure						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
4.06	Where applicable, the EMS system shall identify the availability and staffing of specialty vehicles such as all-terrain vehicles, snowmobiles, water rescue and transportation vehicles.	List of specialty vehicles						
		Staffing policies for specialty vehicles.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

4.07	The EMS system shall develop multi-casualty response plans and procedures that are consistent with NIMS guidelines.	Response plans and procedures						

5 - Facilities/Critical Care								
Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
5.01	The EMS system shall assess, at least annually, the EMS-related capabilities of acute care facilities in its service area.	Annual assessment documentation						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
5.02	The EMS system shall assist hospitals with coordination of pre-hospital triage, transport and transfer destination protocols and agreements.	Agreements and/or protocols						
		Demonstration of efforts to accomplish this standard						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

5.03	The EMS system shall assist hospitals and acute care facilities with planning and preparation for mass casualty management, including procedures for coordinating hospital communications, evacuation, and patient flow.	Procedures and/or log of coordination efforts						
		Demonstrated efforts to accomplish this standards						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
5.04	The EMS system shall monitor the use of the Out of Hospital Trauma Triage Destination Decision Protocol in cooperation with their Trauma Care Facility.	Documentation of trauma audits						
		Documentation of communication with Trauma Care Facilitiy						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
5.05	The EMS system shall participate in the trauma verification process.	Verification of participation in the trauma verification process						

6 - Data Collection/System Evaluation

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
6.01	The EMS system shall establish an EMS CQI program to evaluate the response to emergency medical incidents and the care provided to specific patients. The program shall address the total EMS system, including all pre-hospital provider agencies and hospitals. It shall address compliance with policies, procedures and protocols and identification of preventable morbidity and mortality and document resolution of deficiencies found.	CQI Policy						
		Documentation of compliance with CQI Policy						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

6.02	The EMS system shall conduct audits of out-of-hospital care, including both system response and clinical aspects. The EMS system should have a mechanism to link pre-hospital records with dispatch, emergency department, in-patient, and discharge records.	Documentation of application of system audits that include all aspects of the CQI system						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
6.03	The EMS system shall have a mechanism, in cooperation with the dispatch center, to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of pre-arrival/post dispatch directions.	Evidence of reviews						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

6.04	The EMS system shall establish an evaluation program to evaluate EMS system design and operations, including system effectiveness at meeting community needs, appropriateness of guidelines and standards, prevention strategies that are tailored to community needs, and assessment of resources needed to adequately support the system. This shall include structure, process and outcome evaluations.	Copy of evaluation program						
		Evidence of evaluations						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
6.05	The EMS system shall have the resources to require provider/service participation in the system wide evaluation programs.	Evidence that there is a requirement to participate in the system wide evaluation program (e.g. bylaws, etc.).						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

6.06	The EMS system shall, at least annually, report on the results of its evaluation of EMS system design and operations to their governing agency, local services, and other stakeholders.	Annual report to include list of stakeholders who received a copy and date received						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
6.07	Pre-hospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by Iowa Administrative Code.	Evidence that all responses are being documented and forwarded to appropriate agencies						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
6.08	The EMS system should participate in an integrated data Management system that includes system response and clinical (pre-hospital, hospital and public health) data.	Examples of integrated data collection						

7 - Public Information and Education				
Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
7.01	The EMS system shall promote the development and dissemination of information materials for the public that address: 1. Understanding of EMS system design and operation 2. Proper access to the system 3. Self help (e.g. CPR, first aid, etc) 4. Patient and consumer rights as they relate to the EMS system 5. Health and safety habits as they relate to the prevention and reduction of health risks in target areas 6. Appropriate utilization of emergency departments 7. Promote injury control and preventive medicine	Copies of materials that have been delivered to community (e.g. articles, flyers, class materials, public health fairs, service group presentations, etc.)						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel

7.02	The EMS system, in conjunction with the local office of emergency management (EMA) shall promote citizen disaster preparedness activities.	Copies of articles, flyers, or classes that have been held with EMA on disaster preparedness.						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
7.03	The EMS system shall promote the availability of first aid and CPR training for the general public.	Documentation of training classes provided and number of individuals taught.						

8 - Disaster Medical Response								
Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.01	The EMS system shall participate with their local EMA and Public Health to develop plans, procedures and policy to respond effectively to the medical needs created by disasters.	Local disaster plan						

Number	Standard	Measurement	Status	Implementation Challenges

			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.02	The EMS System shall have medical response plans and procedures for disasters which shall be applicable to incidents caused by a variety of hazards. The EMS System shall have medical response plans and procedures for disasters which shall be applicable to incidents caused by a variety of hazards. a) The EMS system shall annually review the disaster medical response plans. b) The Iowa Office of Home Land Security and Emergency Management Division multi-hazard functional plan should serve as the model for the plans.	Local disaster plan						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.03	The EMS system shall participate with their local EMA in the development and exercise of a plan for activation, operation and deactivation of the emergency operation center.	EOC plan						
		Evidence of particiaption in EOC exercise						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.04	The EMS System shall ensure all EMS providers be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.	Provider training records						
		Documentation showing availability of appropriate PPE						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.05	The EMS system shall ensure that system participants are trained to implement the incident command system.	Record of ICS training for all system participants						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.06	The EMS system shall develop and maintain an inventory of the disaster medical resources that are available for deployment, and update annually.	Annual inventory list of disaster resources						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.07	The EMS system shall develop plans to ensure continuation of EMS services during disasters to the extent possible.	Copy of plan						

Number	Standard	Measurement	Status			Implementation Challenges		
			Completed	In-Progress	Not Started	Fiscal	Time	Personnel
8.08	The EMS system shall encourage hospitals to ensure that their plans for internal and external disasters are fully integrated with the system's medical response plan(s).	Copy of plan						
		Evidence of integration						

Attachment 61

Iowa Code 34A

CHAPTER 34A ENHANCED 911 EMERGENCY TELEPHONE SYSTEMS

This chapter not enacted as a part of this title; transferred from chapter 477B in Code 1993

34A.1 PURPOSE.

The general assembly finds that enhanced 911 emergency telephone communication systems and other emergency 911 notification devices further the public interest and protect the health, safety, and welfare of the people of Iowa. The purpose of this chapter is to enable the orderly development, installation, and operation of enhanced 911 emergency telephone communication systems and other emergency 911 notification devices statewide. These systems are to be operated under governmental management and control for the public benefit.

Section History: Recent Form

88 Acts, ch 1177, §1
C89, § 477B.1
C93, § 34A.1
2004 Acts, ch 1175, §444

34A.2 DEFINITIONS.

As used in this chapter, unless the context otherwise requires:

1. *"Access line"* means an exchange access line that has the ability to access dial tone and reach a public safety answering point.

2. *"Administrator"* means the administrator of the homeland security and emergency management division of the department of

public defense.

3. *"Competitive local exchange service provider"* means the same as defined in section 476.96.

4. *"Emergency 911 notification device"* means a product capable of accessing a public safety answering point through the 911 system.

5. *"Enhanced 911"* or *"E911"* means a service that provides the user of a communications service with the ability to reach a public safety answering point by dialing the digits 911, and that has the following additional features:

a. Routes an incoming 911 call to the appropriate public safety answering point.

b. Automatically provides voice, displays the name, address or location, and telephone number of an incoming 911 call and public safety agency servicing the location.

6. *"Enhanced 911 service area"* means the geographic area to be serviced, or currently serviced under an enhanced 911 service plan, provided that an enhanced 911 service area must at minimum encompass one entire county. The enhanced 911 service area may encompass more than one county, and need not be restricted to county boundaries.

7. *"Enhanced 911 service plan"* means a plan that includes the following information:

a. A description of the enhanced 911 service area.

b. A list of all public and private safety agencies within the enhanced 911 service area.

c. The number of public safety answering points within the enhanced 911 service area.

d. Identification of the agency responsible for management and supervision of the enhanced 911 emergency communication system.

e. (1) A statement of estimated costs to be incurred by the joint E911 service board or the department of public safety, including separate estimates of the following:

(a) Nonrecurring costs, including, but not limited to, public safety answering points, network equipment, software, database, addressing, initial training, and other capital and start-up expenditures, including the purchase or lease of subscriber names, addresses, and telephone information from the local exchange service provider.

(b) Recurring costs, including, but not limited to, network access fees and other telephone charges, software, equipment, and database management, and maintenance, including the purchase or lease of subscriber names, addresses, and telephone information from the local exchange service provider. Recurring costs shall not include personnel costs for a public safety answering point.

(2) Funds deposited in an E911 service fund are appropriated and shall be used for the payment of costs that are limited to nonrecurring and recurring costs directly attributable to the provision of 911 emergency telephone communication service and may include costs for portable and vehicle radios, communication towers and associated equipment, and other radios and associated equipment permanently located at the public safety answering point and as directed by either the joint E911 service board or the department of public safety. Costs do not include expenditures for any other purpose, and specifically exclude costs attributable to other emergency services or expenditures for buildings or personnel, except for the costs of personnel for database management and personnel directly associated with addressing.

f. Current equipment operated by affected local exchange service providers, and central office equipment and technology

upgrades necessary for the provider to implement enhanced 911 service within the enhanced 911 service area.

g. A schedule for implementation of the plan throughout the E911 service area. The schedule may provide for phased implementation.

h. The number of telephone access lines capable of access to 911 in the enhanced 911 service area.

i. The total property valuation in the enhanced 911 service area.

8. *"Local exchange carrier"* means the same as defined in section 476.96.

9. *"Local exchange service provider"* means a vendor engaged in providing telecommunications service between points within an exchange and includes but is not limited to a competitive local exchange service provider and a local exchange carrier.

10. *"Program manager"* means the E911 program manager appointed pursuant to section 34A.2A.

11. *"Provider"* means a vendor who provides, or offers to provide, E911 equipment, installation, maintenance, or exchange access services within the enhanced 911 service area.

12. *"Public or private safety agency"* means a unit of state or local government, a special purpose district, or a private firm which provides or has the authority to provide fire fighting, police, ambulance, emergency medical services, or hazardous materials response.

13. *"Public safety answering point"* means a twenty-four-hour public safety communications facility that receives enhanced 911 service calls and directly dispatches emergency response services or relays calls to the appropriate public or private safety agency.

14. *"Wireless E911 phase 1"* means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and address of the tower that received the call to the appropriate public safety answering point.

15. *"Wireless E911 phase 2"* means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and the latitude and longitude coordinates of the wireless device to the appropriate public safety answering point.

16. *"Wire-line E911 service surcharge"* is a charge set by the E911 service area operating authority and assessed on each wire-line access line which physically terminates within the E911 service area.

Section History: Recent Form

88 Acts, ch 1177, §2
C89, § 477B.2
92 Acts, ch 1139, § 34
C93, § 34A.2
93 Acts, ch 125, § 1; 94 Acts, ch 1199, §45; 98 Acts, ch 1101, § 3, 4, 16; 2004 Acts, ch 1175, §445; 2008 Acts, ch 1032, § 201
Referred to in § 34A.7

34A.2A PROGRAM MANAGER -- APPOINTMENT -- DUTIES.

1. The administrator of the homeland security and emergency management division of the department of public defense shall appoint an E911 program manager to administer this chapter.

2. The E911 program manager shall act under the supervisory control of the administrator of the homeland security and emergency management division of the department of public defense, and in

consultation with the E911 communications council, and perform the duties specifically set forth in this chapter and as assigned by the administrator.

Section History: Recent Form

98 Acts, ch 1101, §5, 16; 2004 Acts, ch 1175, §446
Referred to in §16.161, 34A.2

34A.3 JOINT E911 SERVICE BOARD -- 911 SERVICE PLAN -- IMPLEMENTATION -- WAIVERS.

1. *Joint E911 service boards -- plans.*

a. The board of supervisors of each county shall maintain a joint E911 service board.

(1) Each political subdivision of the state having a public safety agency serving territory within the county is entitled to voting membership on the joint E911 service board. For the purposes of this section, a township that operates a volunteer fire department providing fire protection services to the township, or a city which provides fire protection services through the operation of a volunteer fire department not financed through city government, shall be considered a political subdivision of the state having a public safety agency serving territory within the county. Each private safety agency operating within the area is entitled to nonvoting membership on the board.

(2) A township that does not operate its own public safety agency, but contracts for the provision of public safety services, is not entitled to membership on the joint E911 service board, but its contractor is entitled to membership according to the contractor's status as a public or private safety agency.

b. The joint E911 service board shall maintain an enhanced 911 service plan encompassing at minimum the entire county, unless an exemption is granted by the program manager permitting a smaller E911 service area.

(1) The program manager may grant a discretionary exemption from the single county minimum service area requirement based upon a joint E911 service board's or other E911 service plan operating authority's presentation of evidence which supports the requested exemption if the program manager finds that local conditions make adherence to the minimum standard unreasonable or technically infeasible and that the purposes of this chapter would be furthered by granting an exemption. The minimum size requirement is intended to prevent unnecessary duplication of public safety answering points and minimize other administrative, personnel, and equipment expenses.

(2) The program manager may order the inclusion of a specific territory in an adjoining E911 service plan area to avoid the creation by exclusion of a territory smaller than a single county not serviced by surrounding E911 service plan areas upon request of the joint E911 service board representing the territory.

c. The E911 service plan operating authority shall submit proposed changes to the plan to all of the following:

(1) The program manager.

(2) Public and private safety agencies in the enhanced 911 service area.

(3) Local exchange service providers affected by the enhanced 911 service plan.

2. *Compliance waivers available in limited circumstances.*

a. The program manager may extend the time period for plan implementation by issuing a compliance waiver.

b. The compliance waiver shall be based upon a joint E911 service board's presentation of evidence which supports an extension if the program manager finds that local conditions make implementation financially unreasonable or technically infeasible by the originally scheduled plan of implementation.

c. The compliance waiver shall be for a set period of time, and subject to review and renewal or denial of renewal upon its expiration.

d. The waiver may cover all or a portion of a 911 service plan's enhanced 911 service area to facilitate phased implementation when possible.

e. The granting of a compliance waiver does not create a presumption that the identical or similar waiver will be extended in the future.

f. Consideration of compliance waivers shall be on a case-by-case basis.

3. *Chapter 28E agreement -- alternative to joint E911 service board.*

a. A legal entity created pursuant to chapter 28E by a county or counties, other political divisions, and public or private agencies to jointly plan, implement, and operate a countywide, or larger, enhanced 911 service system may be substituted for the joint E911 service board required under subsection 1. An alternative legal entity created pursuant to chapter 28E as a substitute for a joint E911 service board, as permitted by this subsection, may be created by either:

(1) Agreement of the parties entitled to voting membership on a joint E911 service board.

(2) Agreement of the members of a joint E911 service board.

b. An alternative chapter 28E entity has all of the powers of a joint E911 service board and any additional powers granted by the agreement. As used in this chapter, *"joint E911 service board"* includes an alternative chapter 28E entity created for that purpose, except as specifically limited by the chapter 28E agreement or unless clearly provided otherwise in this chapter. A chapter 28E agreement related to E911 service shall permit the participation of a private safety agency or other persons allowed to participate in a joint E911 service board, but the terms, scope, and conditions of participation are subject to the chapter 28E agreement.

4. *Participation in joint E911 service board required.* A political subdivision or state agency having a public safety agency within its territory or jurisdiction shall participate in a joint E911 service board and cooperate in maintaining the E911 service plan.

Section History: Recent Form

88 Acts, ch 1177, § 3
C89, § 477B.3
89 Acts, ch 168, § 1, 2
C93, § 34A.3
93 Acts, ch 125, § 2; 98 Acts, ch 1101, § 6, 16; 2004 Acts, ch 1175, §447; 2008 Acts, ch 1032, §143; 2008 Acts, ch 1070, §1

34A.4 REQUIREMENTS OF PAY TELEPHONES AND OTHER TELECOMMUNICATIONS DEVICES TO ALLOW 911 CALLS WITHOUT DEPOSITING COINS OR OTHER CHARGE.

In an enhanced 911 service area, a person shall not install or offer for use within the enhanced 911 service area a pay station

telephone or other fixed device unless the telephone or device is capable of making a 911 call without prior insertion of a coin or payment of any other charge, and unless the telephone or device displays notice of free 911 service.

Section History: Recent Form

88 Acts, ch 1177, §4
C89, § 477B.4
C93, § 34A.4
2004 Acts, ch 1175, §448

34A.5 PRIVATE LISTING SUBSCRIBERS AND 911 SERVICE.

Private listing subscribers in an enhanced 911 service area waive the privacy afforded by nonlisted or nonpublished numbers to the extent that the name and address associated with the telephone number may be furnished to the enhanced 911 service system, for all routing, for automatic retrieval of location information, and for associated emergency services.

Section History: Recent Form

88 Acts, ch 1177, §5
C89, § 477B.5
C93, § 34A.5

34A.6 REFERENDUM ON E911 IN PROPOSED SERVICE AREA.

1. Before a joint E911 service board may request imposition of the surcharge by the program manager, the board shall submit the following question to voters, as provided in subsection 2, in the proposed E911 service area, and the question shall receive a favorable vote from a simple majority of persons submitting valid ballots on the following question within the proposed E911 service area:

"Shall the following public measure be adopted?	YES NO	.. ..

Enhanced 911 emergency telephone service shall be funded, in whole or in part, by a monthly surcharge of (an amount determined by the local joint E911 service board of up to one dollar) on each telephone access line collected as part of each telephone subscriber's monthly phone bill if provided within (description of the proposed E911 service area)."

2. The referendum required as a condition of the surcharge imposition in subsection 1 shall be conducted using the following electoral mechanism:

a. At the request of the joint E911 service board a county commissioner of elections shall include the question on the next eligible general election ballot in each electoral precinct to be served, in whole or in part, by the proposed E911 service area, provided the request is timely submitted to permit inclusion.

b. The question may be included in the next election in which all of the voters in the proposed E911 service area will be eligible to vote on the same day.

c. The county commissioner of elections shall report the

results to the joint E911 service board.

d. The joint E911 service board shall compile the results if subscribers from more than one county are included within the proposed service area. The joint E911 service board shall announce whether a simple majority of the compiled votes reported by the commissioner approved the referendum question.

3. The secretary of state, in consultation with the administrator, shall adopt rules for the conduct of joint E911 service referendums as required by and consistent with subsections 1 and 2.

Section History: Recent Form

88 Acts, ch 1177, § 6
C89, § 477B.6
89 Acts, ch 168, § 3; 90 Acts, ch 1144, §1; 91 Acts, ch 129, §27, 28; 92 Acts, ch 1139, § 35
C93, § 34A.6
98 Acts, ch 1101, § 7, 16; 2004 Acts, ch 1175, §449; 2008 Acts, ch 1032, §144
Referred to in §34A.6A, 34A.7, 34A.7A

34A.6A ALTERNATIVE SURCHARGE.

Notwithstanding section 34A.6, the board may request imposition of a surcharge in an amount up to two dollars and fifty cents per month on each telephone access line. The board shall submit the question of the surcharge to voters in the same manner as provided in section 34A.6. If approved, the surcharge may be collected for a period of twenty-four months. At the end of the twenty-four-month period, the rate of the surcharge shall revert to one dollar per month, per access line.

Section History: Recent Form

93 Acts, ch 125, § 3

34A.7 FUNDING -- E911 SERVICE SURCHARGE.

When an E911 service plan is implemented, the costs of providing E911 service within an E911 service area are the responsibility of the joint E911 service board and the member political subdivisions. Costs in excess of the amount raised by imposition of the E911 service surcharge provided for under subsection 1 shall be paid by the joint E911 service board from such revenue sources allocated among the member political subdivisions as determined by the joint E911 service board. Funding is not limited to the surcharge, and surcharge revenues may be supplemented by other permissible local and state revenue sources. A joint E911 service board shall not commit a political subdivision to appropriate property tax revenues to fund an E911 service plan without the consent of the political subdivision. A joint E911 service board may approve an E911 service plan, including a funding formula requiring appropriations by participating political subdivisions, subject to the approval of the funding formula by each political subdivision. However, a political subdivision may agree in advance to appropriate property tax revenues or other moneys according to a formula or plan developed by an alternative chapter 28E entity.

1. *Local wire-line E911 service surcharge imposition.*

a. To encourage local implementation of E911 service, one

source of funding for E911 emergency telephone communication systems shall come from a surcharge per month, per access line on each access line subscriber, except as provided in subsection 5, equal to the lowest amount of the following:

(1) One dollar.

(2) An amount less than one dollar, which would fully pay both recurring and nonrecurring costs of the E911 service system within five years from the date the maximum surcharge is imposed.

(3) The maximum monetary limitation approved by referendum.

b. The surcharge shall be imposed by order of the program manager as follows:

(1) The program manager shall notify a local exchange service provider scheduled to provide exchange access line service to an E911 service area that implementation of an E911 service plan has been approved by the joint E911 service board and by the service area referendum and that collection of the surcharge is to begin within one hundred days.

(2) The program manager shall also provide notice to all affected public safety answering points.

2. *Surcharge collected by local exchange service providers.*

a. The surcharge shall be collected as part of the access line service provider's periodic billing to a subscriber. In compensation for the costs of billing and collection, the local exchange service provider may retain one percent of the gross surcharges collected. If the compensation is insufficient to fully recover a local exchange service provider's costs for billing and collection of the surcharge, the deficiency shall be included in the local exchange service provider's costs for ratemaking purposes to the extent it is reasonable and just under section 476.6. The surcharge shall be remitted to the E911 service operating authority for deposit into the E911 service fund quarterly by the local exchange service provider. The total amount for multiple exchanges may be combined.

b. A local exchange service provider is not liable for an uncollected surcharge for which the local exchange service provider has billed a subscriber but not been paid. The surcharge shall appear as a single line item on a subscriber's periodic billing entitled, "E911 emergency telephone service surcharge".

c. The joint E911 service board may request, not more than once each quarter, the following information from the local exchange service provider:

(1) The identity of the exchange from which the surcharge is collected.

(2) The number of lines to which the surcharge was applied for the quarter.

(3) The number of refusals to pay per exchange if applicable.

(4) Write-offs applied per exchange if applicable.

(5) The number of lines exempt per exchange.

(6) The amount retained by the local exchange service provider generated from the one percent administration fee.

d. Access line counts and surcharge remittances are confidential public records as provided in section 34A.8.

3. *Maximum limit per subscriber billing for surcharge.* An individual subscriber shall not be required to pay on a single periodic billing the surcharge on more than one hundred access lines, or their equivalent, in an E911 service area. A subscriber shall pay the surcharge in each E911 service area in which the subscriber receives access line service.

4. *E911 service fund.* Each joint E911 service board shall establish and maintain as a separate account an E911 service fund.

Any funds remaining in the account at the end of each fiscal year shall not revert to the general funds of the member political subdivisions, except as provided in subsection 5, but shall remain in the E911 service fund. Moneys in an E911 service fund may only be used for nonrecurring and recurring costs of the E911 service plan as approved by the program manager, as those terms are defined by section 34A.2.

5. *Use of moneys in fund -- priority and limitations on expenditure.*

a. Moneys deposited in the E911 service fund shall be used for the repayment of any bonds issued for the benefit of or loan made to the joint E911 service board pursuant to sections 34A.20 through 34A.22, and as long as any such bond or loan remains unpaid the surcharge shall not be reduced or eliminated. Moneys deposited in the fund shall be subject to such terms and conditions as may be contained in the relevant bond documents, trust indenture, resolution, loan agreement, or other instrument pursuant to which bonds are issued or a loan is made, without regard to any limitation otherwise provided by law. The surcharge may be increased, but shall not exceed the maximum allowed in subsection 1, upon approval of the authority upon such terms and conditions as may be contained in the relevant bond documents, trust indenture, resolution, loan agreement, or other instrument pursuant to which bonds are issued or a loan is made, as deemed necessary or prudent by the authority to secure repayment and assure marketability or a reasonable interest rate.

b. Moneys deposited in the E911 service fund shall be used for the following, in order of priority if paragraph *"a"* does not apply:

(1) Money shall first be spent for actual recurring costs of operating the E911 service plan.

(2) If money remains in the fund after fully paying for recurring costs incurred in the preceding year, the remainder may be spent to pay for nonrecurring costs, not to exceed actual nonrecurring costs as approved by the program manager.

(3) If money remains in the fund after fully paying obligations under subparagraphs (1) and (2), the remainder may be accumulated in the fund as a carryover operating surplus. If the surplus is greater than twenty-five percent of the approved annual operating budget for the next year, the program manager shall reduce the surcharge by an amount calculated to result in a surplus of no more than twenty-five percent of the planned annual operating budget. After nonrecurring costs have been paid, if the surcharge is less than the maximum allowed and the fund surplus is less than twenty-five percent of the approved annual operating budget, the program manager shall, upon application of the joint E911 service board, increase the surcharge in an amount calculated to result in a surplus of twenty-five percent of the approved annual operating budget. The surcharge may only be adjusted once in a single year, upon one hundred days' prior notice to the provider.

6. *Limitation of actions -- provider not liable on cause of action related to provision of 911 services.* A claim or cause of action does not exist based upon or arising out of an act or omission in connection with a land-line or wireless provider's participation in an E911 service plan or provision of 911 or local exchange access service, unless the act or omission is determined to be willful and wanton negligence.

7. *Referendum on adjusting maximum of approved surcharge.* If a local option E911 service surcharge was approved by referendum prior to April 4, 1990, the maximum E911 service surcharge monetary limitation may be amended up to a total of one dollar, per month, per

access line, by another referendum as provided in section 34A.6. A joint E911 service board may adjust its E911 service surcharge within the monetary limitation approved by referendum as provided under this subsection by a simple majority vote of the voting members. As a result of the adjustment, the E911 service surcharge, per month, per access line, on each access line subscriber, except as provided in subsection 5, shall not exceed the lowest amount of the following:

a. One dollar.

b. An amount less than one dollar, which would fully pay both recurring and nonrecurring costs of the E911 service system within five years from the date of the adjustment.

c. The maximum monetary limitation approved by referendum.

Section History: Recent Form

88 Acts, ch 1177, § 7
C89, § 477B.7
89 Acts, ch 168, § 4--6; 90 Acts, ch 1144, § 2--4
C93, § 34A.7
98 Acts, ch 1101, § 8, 16; 2004 Acts, ch 1175, §450--452; 2005 Acts, ch 140, §1

34A.7A WIRELESS COMMUNICATIONS SURCHARGE -- FUND ESTABLISHED -- DISTRIBUTION AND PERMISSIBLE EXPENDITURES.

1. *a.* Notwithstanding section 34A.6, the administrator shall adopt by rule a monthly surcharge of up to sixty-five cents to be imposed on each wireless communications service number provided in this state. The surcharge shall be imposed uniformly on a statewide basis and simultaneously on all wireless communications service numbers as provided by rule of the administrator.

b. The program manager shall provide no less than one hundred days' notice of the surcharge to be imposed to each wireless communications service provider. The program manager, subject to the sixty-five cent limit in paragraph *"a"*, may adjust the amount of the surcharge as necessary, but no more than once in any calendar year.

c. (1) The surcharge shall be collected as part of the wireless communications service provider's periodic billing to a subscriber. The surcharge shall appear as a single line item on a subscriber's periodic billing indicating that the surcharge is for E911 emergency telephone service. In the case of prepaid wireless telephone service, this surcharge shall be remitted based upon the address associated with the point of purchase, the customer billing address, or the location associated with the mobile telephone number for each active prepaid wireless telephone that has a sufficient positive balance as of the last days of the information, if that information is available.

(2) In compensation for the costs of billing and collection, the wireless communications service provider may retain one percent of the gross surcharges collected.

(3) The surcharges shall be remitted quarterly by the wireless communications service provider to the program manager for deposit into the fund established in subsection 2.

(4) A wireless communications service provider is not liable for an uncollected surcharge for which the wireless communications service provider has billed a subscriber but which has not been paid.

2. Moneys collected pursuant to subsection 1 shall be deposited

in a separate wireless E911 emergency communications fund within the state treasury under the control of the program manager. Section 8.33 shall not apply to moneys in the fund. Moneys earned as income, including as interest, from the fund shall remain in the fund until expended as provided in this section. Moneys in the fund shall be expended and distributed in the following priority order:

a. An amount as appropriated by the general assembly to the administrator shall be allocated to the administrator and program manager for implementation, support, and maintenance of the functions of the administrator and program manager and to employ the auditor of state to perform an annual audit of the wireless E911 emergency communications fund.

b. The program manager shall allocate twenty-one percent of the total amount of surcharge generated to wireless carriers to recover their costs to deliver E911 phase 1 services. If the allocation in this paragraph is insufficient to reimburse all wireless carriers for such carrier's eligible expenses, the program manager shall allocate a prorated amount to each wireless carrier equal to the percentage of such carrier's eligible expenses as compared to the total of all eligible expenses for all wireless carriers for the calendar quarter during which such expenses were submitted. When prorated expenses are paid, the remaining unpaid expenses shall no longer be eligible for payment under this paragraph.

c. The program manager shall reimburse wire-line carriers on a calendar quarter basis for carriers' eligible expenses for transport costs between the selective router and the public safety answering points related to the delivery of wireless E911 phase 1 services.

d. The program manager shall reimburse wire-line carriers and third-party E911 automatic location information database providers on a calendar quarterly basis for the costs of maintaining and upgrading the E911 components and functionalities beyond the input to the E911 selective router, including the E911 selective router and the automatic location information database.

e. The program manager shall apply an amount up to five hundred thousand dollars per calendar quarter to any outstanding wireless E911 phase 1 obligations incurred pursuant to this chapter prior to July 1, 2004.

f. (1) The program manager shall allocate an amount up to one hundred fifty-nine thousand dollars per calendar quarter equally to the joint E911 service boards and the department of public safety that have submitted an annual written request to the program manager in a form approved by the program manager by May 15 of each year. The program manager shall allocate to each joint E911 service board and to the department of public safety a minimum of one thousand dollars per calendar quarter for each public safety answering point within the service area of the department of public safety or joint E911 service board.

(2) Upon retirement of outstanding obligations referred to in paragraph *"e"*, the amount allocated under this paragraph *"f"* shall be twenty-five percent of the total amount of surcharge generated per calendar quarter allocated as follows:

(a) Sixty-five percent of the total dollars available for allocation shall be allocated in proportion to the square miles of the service area to the total square miles in this state.

(b) Thirty-five percent of the total dollars available for allocation shall be allocated in proportion to the wireless E911 calls taken at the public safety answering point in the service area to the total number of wireless E911 calls originating in this state.

(c) Notwithstanding subparagraph divisions (a) and (b), the minimum amount allocated to each joint E911 service board and to the department of public safety shall be no less than one thousand dollars for each public safety answering point within the service area of the department of public safety or joint E911 service board.

(3) The funds allocated in this paragraph *"f"* shall be used for communication equipment located inside the public safety answering points for the implementation and maintenance of wireless E911 phase 2. The joint E911 service boards and the department of public safety shall provide an estimate of phase 2 implementation costs to the program manager by January 1, 2005.

g. If moneys remain in the fund after fully paying all obligations under paragraphs *"a"* through *"f"*, the remainder may be accumulated in the fund as a carryover operating surplus. This surplus shall be used to fund future phase 2 network and public safety answering point improvements and wireless carriers' transport costs related to wireless E911 services, if those costs are not otherwise recovered by wireless carriers through customer billing or other sources and approved by the program manager. Notwithstanding section 8.33, any moneys remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain available for the purposes of the fund.

h. The administrator, in consultation with the program manager and the E911 communications council, shall adopt rules pursuant to chapter 17A governing the distribution of the surcharge collected and distributed pursuant to this subsection. The rules shall include provisions that all joint E911 service boards and the department of public safety which answer or service wireless E911 calls are eligible to receive an equitable portion of the receipts.

3. *a.* The program manager shall submit an annual report by January 15 of each year to the general assembly's standing committees on government oversight advising the general assembly of the status of E911 implementation and operations, including both wire-line and wireless services, the distribution of surcharge receipts, and an accounting of the revenues and expenses of the E911 program.

b. The program manager shall submit a calendar quarter report of the revenues and expenses of the E911 program to the fiscal services division of the legislative services agency.

c. The general assembly's standing committees on government oversight shall review the priorities of distribution of funds under this chapter at least every two years.

4. The amount collected from a wireless service provider and deposited in the fund, pursuant to section 22.7, subsection 6, information provided by a wireless service provider to the program manager consisting of trade secrets, pursuant to section 22.7, subsection 3, and other financial or commercial operations information provided by a wireless service provider to the program manager, shall be kept confidential as provided under section 22.7. This subsection does not prohibit the inclusion of information in any report providing aggregate amounts and information which does not identify numbers of accounts or customers, revenues, or expenses attributable to an individual wireless communications service provider.

5. For purposes of this section, *"wireless communications service"* means commercial mobile radio service, as defined under sections 3(27) and 332(d) of the federal Telecommunications Act of 1996, 47 U.S.C. § 151 et seq.; federal communications commission rules; and the Omnibus Budget Reconciliation Act of 1993.

"Wireless communications service" includes any wireless two-way communications used in cellular telephone service, personal communications service, or the functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, a personal communications service, or a network access line. *"Wireless communications service"* does not include services whose customers do not have access to 911 or a 911-like service, a communications channel utilized only for data transmission, or a private telecommunications system.

Section History: Recent Form

98 Acts, ch 1101, §9, 16; 99 Acts, ch 96, §5; 2004 Acts, ch 1175, §453--455; 2005 Acts, ch 140, §2; 2007 Acts, ch 213, §21; 2009 Acts, ch 41, §263; 2009 Acts, ch 86, §4

34A.8 LOCAL EXCHANGE SERVICE INFORMATION -- PENALTY.

1. A local exchange service provider shall furnish to the E911 service provider, designated by the joint E911 service board, all names, addresses, and telephone number information concerning its subscribers which will be served by the E911 system and shall periodically update the local exchange service information. The local exchange service provider shall receive as compensation for the provision of local exchange service information charges according to its tariffs on file with and approved by the Iowa utilities board. The tariff charges shall be the same whether or not the local exchange service provider is designated as the E911 service provider by the joint E911 service board.

2. *a.* Subscriber information remains the property of the local exchange service provider.

b. The program manager, joint E911 service board, the designated E911 service provider, and the public safety answering point, their agents, employees, and assigns shall use local exchange service information provided by the local exchange service provider solely for the purposes of providing E911 emergency telephone service or providing related 911 call alert services utilizing only the subscriber's information to a subscriber who consents to the provision of such services, and it shall otherwise be kept confidential. A person who violates this section is guilty of a simple misdemeanor.

c. This chapter does not require a local exchange service provider to sell or provide its subscriber names, addresses, or telephone number information to any person other than the E911 service provider designated by the joint E911 service board.

Section History: Recent Form

88 Acts, ch 1177, §8
C89, § 477B.8
C93, § 34A.8
2004 Acts, ch 1175, §456; 2008 Acts, ch 1032, § 201; 2009 Acts, ch 32, §1
Referred to in § 34A.7

34A.9 TELECOMMUNICATIONS DEVICES FOR THE SPEECH AND HEARING-IMPAIRED.

Each public safety answering point shall provide for the

installation and use of telecommunications devices for the speech and hearing-impaired.

Section History: Recent Form

89 Acts, ch 157, § 1
CS89, § 477B.9
C93, § 34A.9
2004 Acts, ch 1175, §457

34A.10 E911 SELECTIVE ROUTER.

On and after July 1, 2004, only the program manager shall approve access to the E911 selective router.

Section History: Recent Form

2004 Acts, ch 1175, §458

34A.11 THROUGH 34A.14 Reserved.

34A.15 E911 COMMUNICATIONS COUNCIL ESTABLISHED -- DUTIES.

1. An E911 communications council is established. The council consists of the following thirteen members:

a. One person appointed by the commissioner of public safety.

b. One person appointed by the Iowa state sheriffs' and deputies' association.

c. One person appointed by the Iowa association of chiefs of police and peace officers.

d. One person appointed by the Iowa emergency medical services association.

e. One person appointed by the Iowa association of professional firefighters.

f. One person appointed by the Iowa firemen's association.

g. One person appointed by the Iowa chapter of the national emergency number association.

h. One person appointed by the Iowa chapter of the association of public safety communications officials- international, inc.

i. One person appointed by the Iowa emergency management directors association.

j. Two persons appointed by the Iowa telephone association, with one person appointed to represent telephone companies having fifteen thousand or more customers and one person appointed to represent telephone companies having less than fifteen thousand customers.

k. Two persons appointed by the Iowa wireless industry. One appointee shall represent cellular companies and the other appointee shall represent personal communications services companies.

2. The auditor of state or the auditor of state's designee shall serve as an ex officio nonvoting member.

3. The council shall advise and make recommendations to the administrator and program manager regarding the implementation of this chapter. Such advice and recommendations shall be provided on issues at the request of the administrator or program manager or as deemed necessary by the council.

4. A member of the council shall be reimbursed for actual and

necessary expenses incurred in the performance of the member's duties, if such member is not otherwise reimbursed for such expenses.

5. The authority of the council is limited to the issues specifically identified in this section and does not preempt the authority of the utilities board, created in section 474.1, to act on issues within the jurisdiction of the utilities board.

Section History: Recent Form

96 Acts, ch 1219, §64; 98 Acts, ch 1101, § 10--13, 16; 2004 Acts, ch 1175, §459, 460

34A.16 THROUGH 34A.19 Reserved.

34A.20 E911 FINANCING PROGRAM -- DEFINITIONS -- FUNDING -- BONDS AND NOTES.

1. As used in this subchapter, unless the context otherwise requires, *"authority"* means the Iowa finance authority.

2. The authority shall cooperate with the administrator in the creation, administration, and funding of the E911 program established in subchapter I.

3. The authority may issue its bonds and notes for the purpose of funding E911 nonrecurring and recurring costs of one or more E911 service areas.

4. The authority may issue its bonds and notes for the purposes of this chapter and may enter into one or more lending agreements or purchase agreements with one or more bondholders or noteholders containing the terms and conditions of the repayment of and the security for the bonds or notes. The authority and the bondholders or noteholders or a trustee agent designated by the authority may enter into agreements to provide for any of the following:

a. That the proceeds of the bonds and notes and the investments of the proceeds may be received, held, and disbursed by the authority or by a trustee or agent designated by the authority.

b. That the bondholders or noteholders or a trustee or agent designated by the authority may collect, invest, and apply the amount payable under the loan agreements or any other instruments securing the debt obligations under the loan agreements.

c. That the bondholders or noteholders may enforce the remedies provided in the loan agreements or other instruments on their own behalf without the appointment or designation of a trustee. If there is a default in the principal of or interest on the bonds or notes or in the performance of any agreement contained in the loan agreements or other instruments, the payment or performance may be enforced in accordance with the loan agreement or other instrument.

d. Other terms and conditions as deemed necessary or appropriate by the authority.

5. The powers granted the authority under this section are in addition to other powers contained in chapter 16. All other provisions of chapter 16, except section 16.28, subsection 4, apply to bonds or notes issued and powers granted to the authority under this section, except to the extent they are inconsistent with this section.

6. All bonds or notes issued by the authority in connection with the program are exempt from taxation by this state and the interest on the bonds or notes is exempt from state income tax, both personal and corporate.

Section History: Recent Form

90 Acts, ch 1144, §6
C91, § 477B.20
C93, § 34A.20
98 Acts, ch 1101, § 14, 16
Referred to in §16.161, 34A.7, 34A.21

34A.21 SECURITY -- RESERVE FUNDS -- PLEDGES -- NONLIABILITY -- IRREVOCABLE CONTRACTS.

1. The authority may provide in the resolution, trust agreement, or other instrument authorizing the issuance of its bonds or notes pursuant to section 34A.20 that the principal of, premium, and interest on the bonds or notes are payable from any of the following and may pledge the same to its bonds and notes:

a. The income and receipts or other moneys derived from the projects financed with the proceeds of the bonds or notes.

b. The income and receipts or other money derived from designated projects whether or not the projects are financed in whole or in part with the proceeds of the bonds or notes.

c. The amounts on deposit in the E911 service fund of a joint E911 service board, including, but not limited to revenues from a local option E911 service surcharge.

d. The amounts payable to the authority by jurisdictions within service areas pursuant to loan agreements with service areas.

e. Any other funds or accounts established by the authority in connection with the program or the sale and issuance of its bonds or notes.

2. The authority may establish reserve funds to secure one or more issues of its bonds or notes. The authority may deposit in a reserve fund established under this subsection, the proceeds of the sale of its bonds or notes and other money which is made available from any other source.

3. A pledge made in respect of bonds or notes is valid and binding from the time the pledge is made. The money or property so pledged and received after the pledge by the authority is immediately subject to the lien of the pledge without physical delivery or further act. The lien of the pledge is valid and binding as against all persons having claims of any kind in tort, contract, or otherwise against the authority whether or not the parties have notice of the lien. Neither the resolution, trust agreement, or any other instrument by which a pledge is created needs to be recorded, filed, or perfected under chapter 554, to be valid, binding, or effective against all persons.

4. The members of the authority or persons executing the bonds or notes are not personally liable on the bonds or notes and are not subject to personal liability or accountability by reason of the issuance of the bonds or notes.

5. The state pledges to and agrees with the holders of bonds or notes issued under this subchapter that the state will not limit or alter the rights and powers vested in the authority to fulfill the terms of a contract made by the authority with respect to the bonds or notes, or in any way impair the rights and remedies of the holders until the bonds or notes, together with the interest on them including interest on unpaid installments of interest, and all costs and expenses in connection with an action or proceeding by or on behalf of the holders, are fully met and discharged. The authority is authorized to include this pledge and agreement of the state, as

it refers to holders of bonds or notes of the authority, in a contract with the holders.

Section History: Recent Form

90 Acts, ch 1144, §7
C91, § 477B.21
C93, § 34A.21
Referred to in §16.161, 34A.7

34A.22 RULES.

The authority shall adopt rules pursuant to chapter 17A to implement this subchapter.

Section History: Recent Form

90 Acts, ch 1144, §8
C91, § 477B.22
C93, § 34A.22
Referred to in §16.161, 34A.7

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Attachment 62

Iowa Administrative Code 605—10

CHAPTER 10
ENHANCED 911 TELEPHONE SYSTEMS

[Prior to 4/18/90, see Public Defense[601]Ch 10]
[Prior to 5/12/93, Disaster Services Division[607]Ch 10]

605—10.1(34A) Program description. The purpose of this program is to provide for the orderly development, installation, and operation of enhanced 911 emergency telephone systems and to provide a mechanism for the funding of these systems, either in whole or in part. These systems shall be operated under governmental management and control for the public benefit. These rules shall apply to each joint E911 service board or alternative 28E entity as provided in Iowa Code chapter 34A and to each provider of enhanced 911 service.

605—10.2(34A) Definitions. As used in this chapter, unless context otherwise requires:

"*Access line"* means an exchange access line that has the ability to access dial tone and reach a public safety answering point.

"*Automatic location identification (ALI)"* means a system capability that enables an automatic display of information defining a geographical location of the telephone used to place the 911 call.

"*Automatic number identification (ANI)"* means a capability that enables the automatic display of the number of the telephone used to place the 911 call.

"*Call attendant"* means the person who initially answers a 911 call.

"*Call detail recording"* means a means of establishing chronological and operational accountability for each 911 call processed, consisting minimally of the caller's telephone number, the date and time the 911 telephone equipment established initial connection (trunk seizure), the time the call was answered, the time the call was transferred (if applicable), the time the call was disconnected, the trunk line used, and the identity of the call attendant's position, also known as an ANI printout.

"*Call relay method"* means the 911 call is answered at the PSAP, where the pertinent information is gathered, and the call attendant relays the caller's information to the appropriate public or private safety agency for further action.

"*Call transfer method"* means the call attendant determines the appropriate responding agency and transfers the 911 caller to that agency.

"*Central office (CO)"* means a telephone company facility that houses the switching and trunking equipment serving telephones in a defined area.

"*Coin-free access (CFA)"* means coin-free dialing or no-coin dial tone which enables a caller to dial 911 or "0" for operator without depositing money or incurring a charge.

"*Communications service"* means a service capable of accessing, connecting with, or interfacing with a 911 system by dialing, initializing, or otherwise activating the system exclusively through the digits 911 by means of a local telephone device or wireless communications device.

"*Communications service provider"* means a service provider, public or private, that transports information electronically via landline, wireless, internet, cable, or satellite, including but not limited to wireless communications service providers, personal communications service, telematics and voice over internet protocol.

"*Competitive local exchange service provider"* means the same as defined in Iowa Code section 476.96.

"*Conference transfer"* means the capability of transferring a 911 call to the action agency and allowing the call attendant to monitor or participate in the call after it has been transferred to the action agency.

"*Direct dispatch method"* means 911 call answering and radio-dispatching functions, for a particular agency, are both performed at the PSAP.

"*Director,"* unless otherwise noted, means the director of the homeland security and emergency management department.

"*E911 communications council"* means the council as established under the provisions of Iowa

Code section 34A.15.

"E911 program manager" means that person appointed by the director of the homeland security and emergency management department, and working with the E911 communications council, to perform the duties specifically set forth in Iowa Code chapter 34A and this chapter.

"Emergency call" means a telephone request for service which requires immediate action to prevent loss of life, reduce bodily injury, prevent or reduce loss of property and respond to other emergency situations determined by local policy.

"Enhanced 911 (E911)" means the general term referring to emergency telephone systems with specific electronically controlled features, such as ALI, ANI, and selective routing.

"Enhanced 911 (E911) operating authority" means the public entity, which operates an E911 telephone system for the public benefit, within a defined enhanced 911 service area.

"Enhanced 911 (E911) service area" means the geographic area to be served, or currently served under an enhanced 911 service plan, provided that any enhanced 911 service area shall at a minimum encompass one entire county. The enhanced 911 service area may encompass more than one county and need not be restricted to county boundaries. This definition applies only to wire-line enhanced 911 service.

"Enhanced 911 (E911) service plan (wire-line)" means a plan, produced by a joint E911 service board, which includes the information required by Iowa Code subsection 34A.2(7).

"Enhanced 911 service surcharge" means a charge set by the joint E911 service board, approved by local referendum, and assessed on each access line which physically terminates within the E911 service area.

"Enhanced wireless 911 service area" means the geographic area to be served, or currently served, by a PSAP under an enhanced wireless 911 service plan.

"Enhanced wireless 911 service, phase I" means an emergency wireless telephone system with specific electronically controlled features such as ANI, specific indication of wireless communications tower site location, selective routing by geographic location of the tower site.

"Enhanced wireless 911 service, phase II" means an emergency wireless telephone system with specific electronically controlled features such as ANI and ALI and selective routing by geographic location of the 911 caller.

"Exchange" means a defined geographic area served by one or more central offices in which the telephone company furnishes services.

"Implementation" means the activity between formal approval of an E911 service plan and a given system design, and commencement of operations.

"Joint E911 service board" means those entities created under the provisions of Iowa Code section 34A.3, which include the legal entities created pursuant to Iowa Code chapter 28E referenced in Iowa Code subsection 34A.3(3).

"Local exchange carrier" means the same as defined in Iowa Code section 476.96.

"911 call" means any telephone call that is made by dialing the digits 911.

"911 system" means a telephone system that automatically connects a caller, dialing the digits 911, to a PSAP.

"Nonrecurring costs" means one-time charges incurred by a joint E911 service board or operating authority including, but not limited to, expenditures for E911 service plan preparation, surcharge referendum, capital outlay, installation, and initial license to use subscriber names, addresses and telephone information.

"One-button transfer" means another term for a (fixed) transfer which allows the call attendant to transfer an incoming call by pressing a single button. For example, one button would transfer voice and data to a fire agency, and another button would be used for police, also known as "selective transfer."

"Political subdivision" means a geographic or territorial division of the state that would have the following characteristics: defined geographic area, responsibilities for certain functions of local government, public elections and public officers, and taxing power. Excluded from this definition are

departments and divisions of state government and agencies of the federal government.

"Prepaid wireless telecommunications service" means a wireless communications service that provides the right to utilize mobile wireless service as well as other nontelecommunications services, including the download of digital products delivered electronically, content and ancillary services, which must be paid for in advance, and that is sold in predetermined units or dollars of which the amount declines with use in a known amount.

"Provider" means a person, company or other business that provides, or offers to provide, 911 equipment, installation, maintenance, or access services.

"Public or private safety agency" means a unit of state or local government, a special purpose district, or a private firm, which provides or has the authority to provide firefighting, police, ambulance, emergency medical services or hazardous materials response.

"Public safety answering point (PSAP)" means a 24-hour, state, local, or contracted communications facility, which has been designated by the local service board to receive 911 service calls and dispatch emergency response services in accordance with the E911 service plan.

"Public switched telephone network" means a complex of diversified channels and equipment that automatically routes communications between the calling person and called person or data equipment.

"Recurring costs" means repetitive charges incurred by a joint E911 service board or operating authority including, but not limited to, personnel time directly associated with database management and personnel time directly associated with addressing, lease of access lines, lease of equipment, network access fees, and applicable maintenance costs.

"Selective routing (SR)" means an enhanced 911 system feature that enables all 911 calls originating from within a defined geographical region to be answered at a predesignated PSAP.

"Subscriber" means any person, firm, association, corporation, agencies of federal, state and local government, or other legal entity responsible by law for payment for communication service from the telephone utility.

"Tariff" means a document filed by a telephone company with the state telephone utility regulatory commission which lists the communication services offered by the company and gives a schedule for rates and charges.

"Telecommunications device for the deaf (TDD)" means any type of instrument, such as a typewriter keyboard connected to the caller's telephone and involving special equipment at the PSAP which allows an emergency call to be made without speaking, also known as a TTY.

"Telematics" means a vehicle-based mobile data application which can automatically call for assistance if the vehicle is in an accident.

"Trunk" means a circuit used for connecting a subscriber to the public switched telephone network.

"Voice over internet protocol" means a technology used to transmit voice conversations over a data network such as a computer network or internet.

"Wireless communications service" means commercial mobile radio service. "Wireless communications service" includes any wireless two-way communications used in cellular telephone service, personal communications service, or the functional or competitive equivalent of a radio-telephone communications line used in cellular telephone service, a personal communications service, or a network access line. "Wireless communications service" does not include a service whose customers do not have access to 911 or 911-like service, a communications channel utilized only for data transmission, or a private telecommunications system.

"Wireless communications service provider" means a company that offers wireless communications service to users of wireless devices including but not limited to cellular, personal communications services, mobile satellite services, and enhanced specialized mobile radio.

"Wireless communications surcharge" means a surcharge of up to 65 cents imposed on each wireless communications service number provided in this state and collected as part of a wireless communications service provider's monthly billing to a subscriber.

"Wireless E911 phase 1" means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and the address of the tower that received the call to the appropriate public safety answering point.

"Wireless E911 phase 2" means a 911 call made from a wireless device in which the wireless service provider delivers the call-back number and the latitude and longitude coordinates of the wireless device to the appropriate public safety answering point.

"Wire-line E911 service surcharge" means a charge assessed on each wire-line access line which physically terminates within the E911 service area in accordance with Iowa Code section 34A.7.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.3(34A) Joint E911 service boards. Each county board of supervisors shall establish a joint E911 service board.

10.3(1) *Membership.*

a. Each political subdivision of the state, having a public safety agency serving territory within the county E911 service area, is entitled to one voting membership. For the purposes of this paragraph, a township that operates a volunteer fire department providing fire protection services to the township, or a city that provides fire protection services through the operation of a volunteer fire department not financed through the operation of city government, shall be considered a political subdivision of the state having a public safety agency serving territory within the county.

b. Each private safety agency, such as privately owned ambulance services, airport security agencies, and private fire companies, serving territory within the county E911 service area, is entitled to a nonvoting membership on the board.

c. Public and private safety agencies headquartered outside but operating within a county E911 service area are entitled to membership according to their status as a public or private safety agency.

d. A political subdivision that does not operate its own public safety agency but contracts for the provision of public safety services is not entitled to membership on the joint E911 service board. However, its contractor is entitled to one voting membership according to the contractor's status as a public or private safety agency.

e. The joint E911 service board elects a chairperson and vice chairperson.

f. The joint E911 service board shall annually submit a listing of members, to include the political subdivision they represent and, if applicable, the associated 28E agreement, to the E911 program manager. A copy of the list shall be submitted within 30 days of adoption of the operating budget for the ensuing fiscal year and shall be on the prescribed form provided by the E911 program manager.

10.3(2) *Alternate 28E entity.* The joint E911 service board may organize as an Iowa Code chapter 28E agency as authorized in Iowa Code subsection 34A.3(3), provided that the 28E entity meets the voting and membership requirements of Iowa Code subsection 34A.3(1).

10.3(3) *Joint E911 service board bylaws.* Each joint E911 service board shall develop bylaws to specify, at a minimum, the following information:

a. The name of the joint E911 service board.

b. A list of voting and nonvoting members.

c. The date for the commencement of operations.

d. The mission.

e. The powers and duties.

f. The manner for financing activities and maintaining a budget.

g. The manner for acquiring, holding and disposing of property.

h. The manner for electing or appointing officers and terms of office.

i. The manner by which members may vote to include, if applicable, the manner by which votes may be weighted.

j. The manner for appointing, hiring, disciplining, and terminating employees.

k. The rules for conducting meetings.

l. The permissible method or methods to be employed in accomplishing the partial or complete termination of the board and the disposing of property upon such complete or partial termination.

m. Any other necessary and proper rules or procedures.

Each member shall sign the adopted bylaws.

The joint E911 service board shall record the signed bylaws with the county recorder and shall forward a copy of the signed bylaws to the E911 program manager at the homeland security and emergency management department.

10.3(4) *Executive board.* The joint E911 service board may, through its bylaws, establish an executive board to conduct the business of the joint E911 service board. Members of the executive board must be selected from the eligible voting members of the joint E911 service board. The executive board will have such other duties and responsibilities as assigned by the joint E911 service board.

10.3(5) *Meetings.*

a. The provisions of Iowa Code chapter 21, "Official Meetings Open to the Public," are applicable to joint E911 service boards.

b. Joint E911 service boards shall conduct meetings in accordance with their established bylaws and applicable state law.

[**ARC 7695B**, IAB 4/8/09, effective 5/13/09; **ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.4(34A) Enhanced 911 service plan (wire-line).

10.4(1) The joint E911 service board shall be responsible for developing an E911 service plan as required by Iowa Code section 34A.3 and as set forth in these rules. The plan will remain the property of the joint E911 service board. Each joint E911 service board shall coordinate planning with each contiguous joint E911 service board. A copy of the plan and any modifications and addenda shall be submitted to:

a. The homeland security and emergency management department.

b. All public and private safety agencies serving the E911 service area.

c. All providers affected by the E911 service plan.

10.4(2) The E911 service plan shall, at a minimum, encompass the entire county, unless a waiver is granted by the director. Each plan shall include:

a. The mailing address of the joint E911 service board.

b. A list of voting members on the joint E911 service board.

c. A list of nonvoting members on the joint E911 service board.

d. The name of the chairperson and vice chairperson of the joint E911 service board.

e. A geographical description of the enhanced 911 service area.

f. A list of all public and private safety agencies within the E911 service area.

g. The number of public safety answering points within the E911 service area.

h. Identification of the agency responsible for management and supervision of the E911 emergency telephone communication system.

i. A statement of recurring and nonrecurring costs to be incurred by the joint E911 service board. These costs shall be limited to costs directly attributable to the provision of E911 service.

j. The total number of telephone access lines by telephone company or companies having points of presence within the E911 service area and the number of this total that is exempt from surcharge collection as provided in rule 605—10.9(34A) and Iowa Code subsection 34A.7(3).

k. If applicable, a schedule for implementation of the plan throughout the E911 service area. A joint E911 service board may decide not to implement E911 service.

l. The total property valuation in the E911 service area.

m. Maps of the E911 service area showing:

(1) The jurisdictional boundaries of all law enforcement agencies serving the area.

(2) The jurisdictional boundaries of all firefighting districts and companies serving the area.

(3) The jurisdictional boundaries of all ambulance and emergency medical service providers operating in the area.

(4) Telephone exchange boundaries and the location of telephone company central offices, including those located outside but serving the service area.

(5) The location of PSAP(s) within the service area.

n. A block drawing for each telephone central office within the service area showing the method by which the 911 call will be delivered to the PSAP(s).

o. A plan to migrate to an internet protocol-enabled next generation network.

10.4(3) All plan modifications and addenda shall be filed with, reviewed, and approved by the E911 program manager.

10.4(4) The E911 program manager shall base acceptance of the plan upon compliance with the provisions of Iowa Code chapter 34A and the rules herein.

10.4(5) The E911 program manager will notify in writing, within 20 days of review, the chairperson of the joint E911 service board of the approval or disapproval of the plan.

a. If the plan is disapproved, the joint E911 service board will have 90 days from receipt of notice to submit revisions/addenda.

b. Notice for disapproved plans will contain the reasons for disapproval.

c. The E911 program manager will notify the chairperson, in writing within 20 days of review, of the approval or disapproval of the revisions.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.5(34A) Wire-line E911 service surcharge.

10.5(1) One source of funding for the E911 emergency communications system shall come from a surcharge of one dollar per month, per access line on each access line subscriber.

10.5(2) The E911 program manager shall notify a local communications service provider scheduled to provide exchange access E911 service within an E911 service area that implementation of an E911 service plan has been approved by the joint E911 service board and by the E911 program manager and that collection of the surcharge is to begin within 60 days. The E911 program manager shall also provide notice to all affected public safety answering points. The 60-day notice to local exchange service providers shall also apply when an adjustment in the wire-line surcharge rate is made.

10.5(3) The local communications service provider shall collect the surcharge as a part of its monthly billing to its subscribers. The surcharge shall appear as a single line item on a subscriber's monthly billing entitled "E911 emergency communications service surcharge."

10.5(4) The local communications service provider may retain 1 percent of the surcharge collected as compensation for the billing and collection of the surcharge. If the compensation is insufficient to fully recover a provider's costs for the billing and collection of the surcharge, the deficiency shall be included in the provider's costs for rate-making purposes to the extent it is reasonable and just under Iowa Code section 476.6.

10.5(5) The local communications service provider shall remit the collected surcharge to the joint E911 service board on a calendar quarter basis within 20 days of the end of the quarter.

10.5(6) The joint E911 service board may request, not more than once each quarter, the following information from the local communications service provider:

a. The identity of the exchange from which the surcharge is collected.

b. The number of lines to which the surcharge was applied for the quarter.

c. The number of refusals to pay per exchange, if applicable.

d. The number of write-offs per exchange, if applicable.

e. The number of lines exempt per exchange.

f. The amount retained by the local communications service provider from the 1 percent

administrative fee.

Access line counts and surcharge remittances are confidential public records as provided in Iowa Code section 34A.8.

10.5(7) Collection for a surcharge shall terminate if E911 service ceases to operate within the respective E911 service area. The E911 program manager for good cause may grant an extension.

a. The director shall provide 100 days' prior written notice to the joint E911 service board or the operating authority and to the local communications service provider(s) collecting the fee of the termination of surcharge collection.

b. Individual subscribers within the E911 service area may petition the joint E911 service board or the operating authority for a refund. Petitions shall be filed within one year of termination. Refunds may be prorated and shall be based on funds available and subscriber access lines billed.

c. At the end of one year from the date of termination, any funds not refunded and remaining in the E911 service fund and all interest accumulated shall be retained by the joint E911 service board. However, if the joint E911 service board ceases to operate any E911 service, the balance in the E911 service fund shall be payable to the homeland security and emergency management department. Moneys received by the department shall be used only to offset the costs for the administration of the E911 program.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.6(34A) Waivers, variance request, and right to appeal.

10.6(1) All requests for variances or waivers shall be submitted to the E911 program manager in writing and shall contain the following information:

a. A description of the variance(s) or waiver(s) being requested.

b. Supporting information setting forth the reasons the variance or waiver is necessary.

c. A copy of the resolution or minutes of the joint E911 service board meeting which authorizes the application for a variance or waiver.

d. The signature of the chairperson of the joint E911 service board.

10.6(2) The E911 program manager may grant a variance or waiver based upon the provisions of Iowa Code chapter 34A or other applicable state law.

10.6(3) Upon receipt of a request for a variance or waiver, the E911 program manager shall evaluate the request and schedule a review within 20 working days of receipt of the request. Review shall be informal and the petitioner may present materials, documents and testimony in support of the petitioner's request. The E911 program manager shall determine if the request meets the criteria established and shall issue a decision within 20 working days. The E911 program manager shall notify the petitioner, in writing, of the acceptance or rejection of the petition. If the petition is rejected, such notice shall include the reasons for denial.

605—10.7(34A) Enhanced wireless E911 service plan. Each joint E911 service board, the department of public safety, the E911 communications council, and wireless service providers shall cooperate with the E911 program manager in preparing an enhanced wireless E911 service plan for statewide implementation of enhanced wireless E911 service.

10.7(1) *Plan specifications.* The enhanced wireless E911 service plan shall include, at a minimum, the following information:

1. Maps showing the geographic location within the county of each PSAP that receives enhanced wireless E911 telephone calls.
2. A list of all public safety answering points within the state of Iowa.
3. A set of guidelines for determining eligible cost as set forth in Iowa Code section 34A.7A.
4. A schedule for the implementation and maintenance of the next generation 911 systems to provide enhanced wireless 911 phase I and phase II service.

10.7(2) *Adoption by reference.* The "Wireless NG911 Implementation and Operations Plan," effective July 1, 2013, and available from the Homeland Security and Emergency Management Department,

7105 NW 70th Avenue, Camp Dodge, Bldg. W-4, Johnston, Iowa, or at the Law Library in the Capitol Building, Des Moines, Iowa, is hereby adopted by reference effective June 18, 2014.
[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.8(34A) Emergency communications service surcharge.

10.8(1) The E911 program manager shall adopt a monthly surcharge of one dollar to be imposed on each wireless communications service number provided in this state. The surcharge shall not be imposed on wire-line-based communications or prepaid wireless telecommunications service.

10.8(2) The E911 program manager shall order the imposition of a surcharge uniformly on a statewide basis and simultaneously on all communications service numbers by giving at least 60 days' prior notice to wireless carriers to impose a monthly surcharge as part of their periodic billings. The 60-day notice to wireless carriers shall also apply when making an adjustment in the wireless surcharge rate.

10.8(3) The wireless surcharge shall be one dollar per month, per customer service number, until changed by rule.

10.8(4) The communications service provider shall list the surcharge as a separate line item on the customer's billing indicating that the surcharge is for E911 emergency telephone service. The communications service provider is entitled to retain 1 percent of any wireless surcharge collected as a fee for collecting the surcharge as part of the subscriber's periodic billing. The wireless E911 surcharge is not subject to sales or use tax.

10.8(5) Surcharge funds shall be remitted on a calendar quarter basis by the close of business on the twentieth day following the end of the quarter with a remittance form as prescribed by the E911 program manager. Providers shall issue their checks or warrants to the Treasurer, State of Iowa, and remit to the E911 Program Manager, Homeland Security and Emergency Management Department, 7105 NW 70th Avenue, Camp Dodge, Bldg. W-4, Johnston, Iowa 50131.
[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.9(34A) E911 emergency communications fund.

10.9(1) Wireless E911 surcharge money, collected and remitted by wireless service providers, shall be placed in a fund within the state treasury under the control of the director.

10.9(2) Iowa Code section 8.33 shall not apply to moneys in the fund. Moneys earned as income, including as interest, from the fund shall remain in the fund until expended as provided in this subrule. However, moneys in the fund may be combined with other moneys in the state treasury for purposes of investment.

10.9(3) Moneys in the fund shall be expended and distributed in the order and manner as follows:

a. An amount as appropriated by the general assembly shall be allocated to the homeland security and emergency management department for implementation, support, and maintenance of the functions of the E911 program and to employ the auditor of the state to perform an annual audit of the wireless E911 emergency communications fund.

b. The program manager shall reimburse local communications service providers on a calendar quarter basis for their expenses for transport costs between the wireless E911 selective router and the public safety answering points related to the delivery of wireless E911 service.

c. The program manager shall reimburse local communications service providers and third-party E911 automatic location information (ALI) database providers on a calendar quarter basis for the costs of maintaining and upgrading the E911 components and functionalities between the input and output points of the wireless E911 selective router. This includes the wireless E911 selective router and the automatic location information (ALI) database.

d. The program manager shall allocate 13 percent of the total amount of surcharge generated per calendar quarter to wireless carriers to recover their costs to deliver wireless E911 phase I services as defined in the Federal Communications Commission (FCC) Docket 94-102 and further defined in the

FCC's letter to King County, Washington, dated May 7, 2001. If this allocation is insufficient to reimburse all wireless carriers for the wireless service provider's eligible expenses, the program manager shall allocate a prorated amount to each wireless carrier equal to the percentage of the provider's eligible expenses as compared to the total of all eligible expenses for all wireless carriers for the calendar quarter during which expenses were submitted. When prorated expenses are paid, the remaining unpaid expenses shall no longer be eligible for payment under this paragraph. This allocation is for the period beginning July 1, 2013, and ending June 30, 2016.

e. A minimum of $1,000 per calendar quarter shall be allocated for each public safety answering point with the E911 service area of the department of public safety or joint E911 service board that has submitted a written request to the program manager. The written request shall be made with the Request for Wireless E911 Fund form contained in the Wireless NG911 Implementation and Operations Plan. The request is due to the program manager on May 15, or the next business day, of each year.

The amount allocated under 10.9(3)*"e"* shall be 46 percent of the total amount of surcharge generated per calendar quarter. The minimum amount allocated to the department of public safety and the joint E911 service boards shall be $1,000 per PSAP operated by the respective authority. Additional funds shall be allocated as follows:

(1) Sixty-five percent of the total dollars available for allocation shall be allocated in proportion to the square miles of the E911 service area to the total square miles in the state.

(2) Thirty-five percent of the total dollars available for allocation shall be allocated in proportion to the wireless E911 calls answered at the public safety answering point in the E911 service area to the total of wireless E911 calls originating in the state.

(3) Funds allocated under 10.9(3)*"e"* shall be deposited in the E911 service fund and shall be used for communications equipment utilized by the public safety answering points for the implementation and maintenance of E911 services.

f. If moneys remain after all obligations under 10.9(3)*"a"* to *"e,"* as listed above, have been fully paid, the remainder may be accumulated as a carryover operating surplus. These moneys shall be used to fund future network improvements and public safety answering point improvements. These moneys may also be used for wireless service providers' transport costs related to wireless E911 phase II services, if those costs are not otherwise recovered by the wireless service provider's customer billing or other sources and are approved by the program manager. Any moneys remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain available for the purposes of the fund.

10.9(4) Payments to local communications service providers and wireless service providers shall be made quarterly, based on original, itemized claims or invoices presented within 20 days of the end of the calendar quarter. Claims or invoices not submitted within 20 days of the end of the calendar quarter are not eligible for reimbursement and may not be included in future claims and invoices. Payments to providers shall be made in accordance with these rules and the State Accounting Policy and Procedures Manual.

10.9(5) Local communications service providers shall be reimbursed for only those items and services that are defined as eligible in the enhanced wireless 911 service plan and when initiation of service has been ordered and authorized by the E911 program manager.

10.9(6) If it is found that an overpayment has been made to an entity, the E911 program manager shall attempt recovery of the debt from the entity by certified letter. Due diligence shall be documented and retained at the homeland security and emergency management department. If resolution of the debt does not occur and the debt is at least $50, the homeland security and emergency management department will then utilize the income offset program through the department of revenue. Until resolution of the debt has occurred, the homeland security and emergency management department may withhold future payments to the entity.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.10(34A) E911 surcharge exemptions. The following agencies, individuals, and organizations are exempt from imposition of the E911 surcharge:

1. Federal agencies and tax-exempt instrumentalities of the federal government.
2. Indian tribes for access lines on the tribe's reservation upon filing a statement with the joint E911 service board, signed by appropriate authority, requesting surcharge exemption.
3. An enrolled member of an Indian tribe for access lines on the reservation, who does not receive E911 service, and who annually files a signed statement with the joint E911 service board that the person is an enrolled member of an Indian tribe living on a reservation and does not receive E911 service. However, once E911 service is provided, the member is no longer exempt.
4. Official station testing lines owned by the provider.
5. Individual wire-line subscribers to the extent that they shall not be required to pay on a single periodic billing the surcharge on more than 100 access lines, or their equivalent, in an E911 service area.

All other subscribers not listed above, that have or will have the ability to access 911, are required to pay the surcharge, if imposed by the official order of the E911 program manager.

605—10.11(34A) E911 service fund.

10.11(1) The department of public safety and each joint E911 service board have the responsibility for the E911 service fund.

a. An E911 service fund shall be established in the office of the county treasurer for each joint E911 service board and with the state treasurer for the department of public safety.

b. Collected surcharge moneys and any interest thereon, as authorized in Iowa Code chapter 34A, shall be deposited into the E911 service fund. E911 surcharge moneys must be kept separate from all other sources of revenue utilized for E911 systems.

c. For joint E911 service boards, withdrawal of moneys from the E911 service fund shall be made on warrants drawn by the county auditor, per Iowa Code section 331.506, supported by claims and vouchers approved by the chairperson or vice chairperson of the joint E911 service board or the appropriate operating authority so designated in writing.

d. For the department of public safety, withdrawal of moneys from the E911 service fund shall be made in accordance with state laws and administrative rules.

10.11(2) The E911 service funds shall be subject to examination by the department at any time during usual business hours. E911 service funds are subject to the audit provisions of Iowa Code chapter 11. A copy of all audits of the E911 service fund shall be furnished to the department within 30 days of receipt. If through the audit or monitoring process the department determines that a joint E911 service board is not adhering to an approved plan or does not have a valid board membership, or if the department determines that a joint E911 service board or the department of public safety is not using funds in the manner prescribed in these rules or Iowa Code chapter 34A, the director may, after notice and hearing, suspend surcharge imposition and order termination of expenditures from the E911 service fund. The joint E911 service board or department of public safety is not eligible to receive or expend surcharge moneys until such time as the E911 program manager determines that the board or department of public safety is in compliance with the approved plan, board membership, and fund usage limitations.

[**ARC 8314B**, IAB 11/18/09, effective 12/23/09; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.12(34A) Operating budgets. By March 31 of each year, each joint E911 service board and the department of public safety shall provide to the E911 program manager a copy of the operating budget for the ensuing fiscal year for the fund as established under subrule 10.11(1).

[**ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.13(34A) Limitations on use of funds. Surcharge moneys in the E911 service fund may be used to pay recurring and nonrecurring costs including, but not limited to, network equipment, software, database, addressing, initial training, and other start-up, capital, and ongoing expenditures.

E911 surcharge moneys shall be used only to pay costs directly attributable to the provision of E911 telephone systems and services and may include costs directly attributable to the receipt and disposition of the 911 call.
[**ARC 0602C**, IAB 2/20/13, effective 3/27/13]

605—10.14(34A) Minimum operational and technical standards.

10.14(1) Each E911 system, supplemented with E911 surcharge moneys, shall, at a minimum, employ the following features:

a. ALI (automatic location identification).

b. ANI (automatic number identification).

c. Ability to selectively route.

d. Each PSAP shall provide two emergency seven-digit numbers arranged in rollover configuration for use by telephone company operators for transferring a calling party to the PSAP over the wire-line network. Wireless calls must be transferred to PSAPs that are capable of accepting ANI and ALI.

e. ANI and ALI information shall be maintained and updated in such a manner as to allow for 95 percent or greater degree of accuracy.

10.14(2) E911 public safety answering points shall adhere to the following minimum standards:

a. The PSAP shall operate 7 days per week, 24 hours per day, with operators on duty at all times.

b. The primary published emergency number in the E911 service area shall be 911.

c. All PSAPs will maintain interagency communications capabilities for emergency coordination purposes, to include radio as well as land line direct or dial line.

d. Each PSAP shall develop and maintain a PSAP standard operating procedure for receiving and dispatching emergency calls.

e. The date and time of each 911 emergency call shall be documented using an automated call detail recording device or other communications center log. Such logs shall be maintained for a period of not less than one year.

f. If a call transfer method of handling 911 calls is employed, a 99 percent degree of reliability of transferred calls from a PSAP to responding agencies shall be maintained. All transferred calls shall employ, to the closest extent possible, conference transfer capabilities which provide that the call be announced and monitored by the PSAP operator to ensure that the call has been properly transferred.

g. PSAPs not employing the transfer method of handling 911 emergency calls shall use the call relay method. Information shall be exchanged between the PSAP receiving the call and an appropriate emergency response agency or dispatch center having jurisdiction in the area of the emergency. In no case during an emergency 911 call shall the caller be referred to another telephone number and required to hang up and redial. The call relay method shall also prevail in circumstances where emergency calls enter the 911 system (whether by design or by happenstance) from outside the E911 service area.

h. Access control and security of PSAPs and associated dispatch centers shall be designed to prevent disruption of operations and provide a safe and secure environment of communication operations.

i. PSAP supervision shall ensure that all telephone company employees, whose normal activities may involve contact with facilities associated with the 911 service, are familiar with safeguarding of facilities' procedures.

j. Emergency electrical power shall be provided for the PSAP environment that will ensure continuous operations and communications during a power outage. Such power should start automatically in the event of power failure and shall have the ability to be sustained for a minimum of 48 hours.

k. The PSAP shall make every attempt to disallow the intrusion by automatic dialers, alarm systems, or automatic dialing and announcing devices on a 911 trunk. If intrusion by one of these devices should occur, those responsible for PSAP operations shall make every attempt to contact the

responsible party to ensure there is no such further occurrence by notifying the party that knowing and intentional interference with emergency telephone calls constitutes a crime under Iowa Code section 727.5. Those responsible for PSAP operations shall report persons who repeatedly use automatic dialers, alarm systems, or automatic announcing devices on 911 trunk lines to the county attorney for investigation of possible violations of section 727.5.

l. Each PSAP shall be equipped with an appropriate telecommunications device for the deaf (TDD) in accordance with 28 CFR Part 35.162, July 26, 1991.

10.14(3) Communications service providers shall adhere to the following minimum requirements:

a. The PSAP and E911 program manager shall be notified of all service interruptions in accordance with 47 CFR Part 4.

b. All communications service providers shall submit separate itemized bills to the E911 program manager, the department of public safety, a joint E911 service board or PSAP operating authority, as appropriate.

c. The communications service provider shall respond, within a reasonable length of time, to all appropriate requests for information from the director, the department of public safety, a joint E911 service board or operating authority and shall expressly comply with the provisions of Iowa Code section 34A.8.

d. Access to the wireless E911 selective router shall be approved by the E911 program manager. Communications service providers must provide the company name, address and point of contact with their request. If the communications service provider utilizes a third-party vendor, the vendor must provide this information listing the vendor's customer's requested information.

10.14(4) Voluntary standards. Current technical and operational standards applying to E911 systems and services can be found in the "American Society for Testing and Materials Standard Guide for Planning and Developing 911 Enhanced Telephone Systems" and in publications issued by the National Emergency Number Association. Master street address guides are encouraged to be developed and maintained by using National Emergency Number Association technical standards 02-010 and 02-011. Standards contained in these documents shall be considered as guidance, and adherence thereto shall be voluntary. Notwithstanding the minimum standards published in these rules, it is intended that E911 communications service providers and joint E911 service boards and operating authorities employ the best and most affordable technologies and methods available in providing E911 services to the public.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.15(34A) Administrative hearings and appeals.

10.15(1) E911 program manager decisions regarding the acceptance or refusal of an E911 service plan, in whole or in part, the implementation of E911 and the imposition of the E911 surcharge within a specific E911 service area may be contested by an affected party.

10.15(2) Request for hearing shall be made in writing to the homeland security and emergency management department director within 30 days of the E911 program manager's mailing or serving a decision and shall state the reason(s) for the request and shall be signed by the appropriate authority.

10.15(3) The director shall schedule a hearing within 10 working days of receipt of the request for hearing. The director shall preside over the hearing, at which time the appellant may present any evidence, documentation, or other information regarding the matter in dispute.

10.15(4) The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(5) Any party adversely affected by the director's ruling may file a written request for a rehearing within 20 days of issuance of the ruling. A rehearing will be conducted only when additional evidence is available, the evidence is material to the case, and good cause existed for the failure to present the evidence at the initial hearing. The director will schedule a hearing within 20 days after the receipt of the written request. The director shall issue a ruling regarding the matter within 20 working days of the hearing.

10.15(6) Any party adversely affected by the director's ruling may file a written appeal to the director of the homeland security and emergency management department. The appeal request shall contain information identifying the appealing party, the ruling being appealed, specific findings or conclusions to which exception is taken, the relief sought, and the grounds for relief. The director shall issue a ruling regarding the matter within 90 days of the hearing. The director's ruling constitutes final agency action for purposes of judicial review.

[**ARC 7695B**, IAB 4/8/09, effective 5/13/09; **ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.16(34A) Confidentiality. All financial or operations information provided by a communications service provider to the E911 program manager shall be identified by the provider as confidential trade secrets under Iowa Code section 22.7(3) and shall be kept confidential as provided under Iowa Code section 22.7(3) and Iowa Administrative Code 605—Chapter 5. Such information shall include numbers of accounts, numbers of customers, revenues, expenses, and the amounts collected from said communications service provider for deposit in the fund. Notwithstanding such requirements, aggregate amounts and information may be included in reports issued by the director if the aggregated information does not reveal any information attributable to an individual communications service provider.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13; **ARC 1538C**, IAB 7/9/14, effective 8/13/14]

605—10.17(34A) Prepaid wireless E911 surcharge. Administration of the prepaid wireless E911 surcharge is under the control of the Iowa department of revenue. To administer this function, the department has adopted rules that can be found in 701—paragraph 224.6(2)*"b"* and rule 701—224.8(34A), Iowa Administrative Code.

[**ARC 0602C**, IAB 2/20/13, effective 3/27/13]

These rules are intended to implement Iowa Code chapter 34A.

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[Filed ARC 8314B (Notice ARC 8184B, IAB 9/23/09), IAB 11/18/09, effective 12/23/09]
[Filed ARC 0602C (Notice ARC 0512C, IAB 12/12/12), IAB 2/20/13, effective 3/27/13]
[Filed ARC 1538C (Notice ARC 1463C, IAB 5/14/14), IAB 7/9/14, effective 8/13/14]

[1] Effective date of 8/2/89 delayed 70 days by the Administrative Rules Review Committee at its July 11, 1989, meeting.

Attachment 63

Iowa Trauma Plan

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	Mercy Health Center, Dubuque	3.	Pramila Singh, RN, M.B.A. by Norma Steffm RN,BSN
	Marian Health Center, Sioux City	4.	Gary Carlton, M.D., F.A.C.S.
	St. Luke's, Cedar Rapids	5.	William E. Kettelcamp, M.D.
	AllenMemeorial Hospital, Waterloo	6.	Jan Woodman, RN, C.E.N.
	Finley Hospital, Dubuque	7.	Pam Fincel, RN, CCRN
	Mercy Hospital Medical Center, Des Moines	8.	Jeri Babb RN, MSN, CCRN
	North Iowa Mercy Health Center, Mason City	9.	Marsha Wedmore RN,CCRN
	Mercy Medical Center, Cedar Rapids	10.	Carol Watson, Vice President
2.	Iowa Regional EMS Councils	11.	Anne Koontz, EMT-D (Sioux-Lakes)
3.	Iowa EMS Association	12.	Mark T. Postma, EMT-Paramedic
4.	Iowa Governor's Traffic Safety Bureau	13.	J. Michael Laski
5.	Iowa Hospital Association	14.	Art Spies
6.	American College of Surgeons, COT	15.	David Sidney, M.D., F.A.C.S.
7.	American College of Emergency Physicians	16.	G. Leon Berkley, D.O., F.A.C.E.P.
8.	Iowa Medical Society	17.	Thomas Foley, M.D., F.A.C.S.
9.	Iowa State Medical Examiner	18.	Thomas L. Bennett, M.D.
10.	Iowa Department of Public Health:		
	Project Manager (EMS Section)	19.	Dick Harmon, EMT-P
	Principal Investigator	20.	Tim Peterson, M.D., F.A.C.E.P.
	TISP Contractor (University of Iowa)	21.	Craig Zwerling, M.D., Ph.D.,M.P.H.
	Iowa Health Data Commission	22.	Pierce Wilson, M.S.W.
11.	Iowa Nurse's Assoc./Emergency Nurse's Assoc.	23.	Alice Prochaska, RN, BSN, CEN
12.	Iowa Osteopathic Medical Association	24.	Mark Randleman, D.O., F.A.C.E.P.
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Revised: November 16. 1994

PROBLEM STATEMENT

WHY AN IOWA TRAUMA SYSTEM?

- Injury is the leading cause of death up to age 37.
- Injuries are the number one killer of children.
- The death rate for injury victims over 65 is nearly double the rate for younger victims.
- For every death from injury, there are three persons left with serious and permanent disability.
- Rural citizens have more than twice the death rate from injury than urban citizens, often as a result of inadequate access to organized trauma services.
- In 1992, 46% of all work-related accidental deaths were farm related.

For major injury victims who have a chance to live, approximately one in five die because they do not have access to organized trauma services.

The Iowa Trauma Plan and proposed legislation are essential to making an organized trauma system available to all citizens of Iowa.

EXECUTIVE SUMMARY

Iowa **Trauma Plan**

1994

Traumatic injury is the leading cause of death for persons from 1 to 37 years of age, costing an estimated $407.5 billion in the United States in 1993. In Iowa, during 1993, a total of 1,021 persons died from traumatic injury, and nearly one half of these deaths (463) were due to motor vehicle crashes. An estimated 300,000 persons present yearly for emergency evaluation and treatment in Iowa due to injury, costing Iowans increased medical expense and lost time in work and wages.

The goal of a trauma care system is to match the injured patient's needs to the existing resources so that optimal and cost-effective care is achieved. Trauma care represents a continuum of care that is best provided by an integrated system extending from prevention, to acute care and through rehabilitation. This requires cooperation of trauma care providers and resources in each phase of care. A systems approach to trauma care recognizes this continuum of care and reduces costs, disability and death associated with traumatic injury.

Trauma system development for the State of Iowa is geared to achieve this goal in recognition of the unique needs of the predominant rural environment in the state. The Iowa Trauma Systems Development Consortium has met during the past two years to

evaluate Iowa's needs for a system of trauma care and has prepared this *Iowa Trauma Plan* to assist in the development of a Trauma System for the State oflowa. In summary, the *Iowa Trauma Plan* recommends the following action steps to be taken:

Leadership

- Establish the Iowa Department of Public Health as the lead agency for development and coordination of the statewide trauma system.
- Establish the Trauma Systems Advisory Council (TSAC) and System Evaluation and Quality Improvement Committee (SEQIC) to provide representation and expertise necessary for developing standards of care, protocols, hospital categorization policies, public information and education goals, patient advocacy, and system evaluation.
- Develop medical direction at the state level to assure medical accountability and credibility for the EMSff rauma Care System.

System Development

- Implement an *inclusive trauma care system* in which each willing provider and facility is part of the trauma care system.

Legislation

- Develop effective trauma care legislation to be introduced in the 1995 legislative session which addresses the legal authority of system implementation and maintenance.

Finance

- Establish a dedicated funding mechanism to provide fiscal support at all levels of the trauma care system.

Human Resources

- Develop staff positions at the Iowa Department of Public Health to effectively manage the trauma care system.
- Develop trauma care training for patient care providers along the continuum of trauma care.

Prehospital Care

- Improve the Emergency Medical Service (EMS) dispatch system by enhanced dispatch training and quality improvement programs for all communication processes.
- Enhance the role of medical direction for EMS including physician involvement at the state level and for basic care services.

- Develop trauma triage based on physiologic, anatomic and mechanism of injury criteria.
- Establish minimum standards for all ambulance services.

Definitive Care

- Recognize the need for standards for trauma facilities and their categorization based upon level of care capability/commitment.

Evaluation

- Develop a comprehensive system quality improvement program to address injury care along the continuum of care, to determine clusters of injury and high risk groups, and to focus on injury prevention programs through public information and education and through improvements in the trauma care delivery system.

Development and maintenance of a trauma system for the State of Iowa is a challenging commitment for health care providers and public policy makers. An *inclusive trauma system* as recommended by this plan has the potential to benefit all Iowans with reduced suffering, disability, death and lower medical costs associated with traumatic injury.

LEADERSHIP

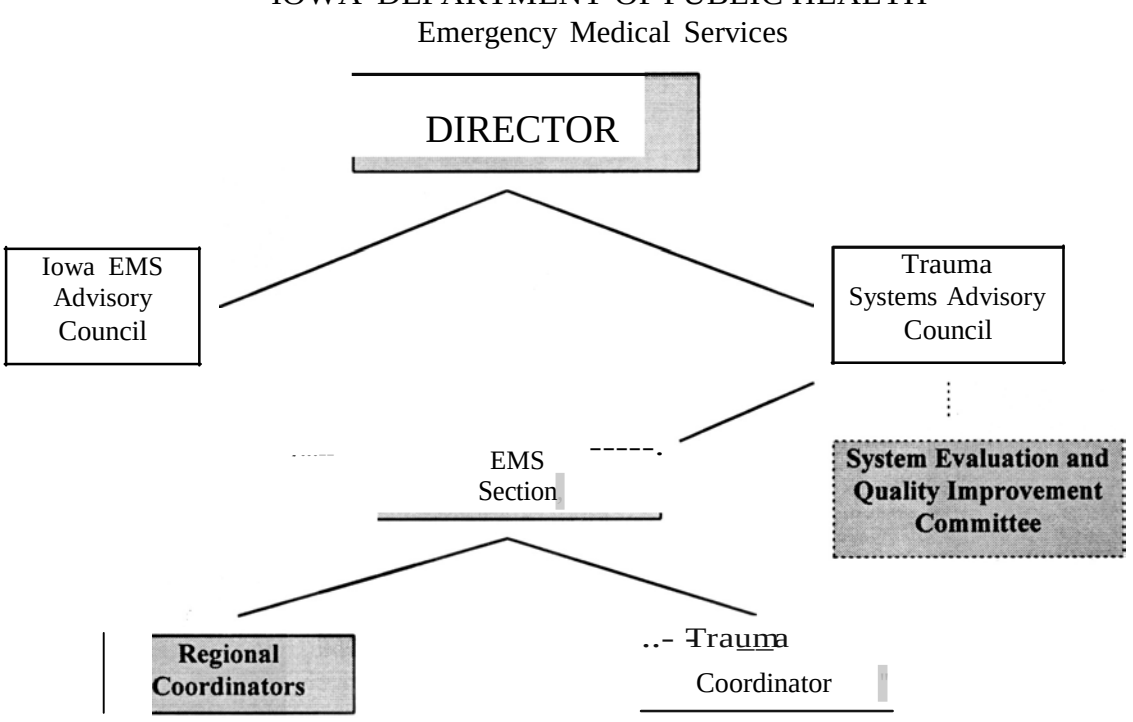
LEADERSHIP

LEAD AGENCY

Trauma care is an integral part of Emergency Medical Service (EMS) systems. The development of a trauma system is best accomplished through the designation of a state lead agency to organize the development of the system, coordinate both EMS and trauma resources, seek input from key participants at each stage of development and negotiate workable policies. Working with medical and professional societies the lead agency is responsible for establishing the minimum standards for system performance and patient care.

The Iowa Department of Public Health (IDPH) is proposed to be the lead agency for the EMSffrauma System. Future legislation should enable the Department with the regulatory authority, responsibility, and resources available to develop and implement the trauma system, coordinate resources and integrate all system components. The EMS section within the IDPH has provided leadership toward trauma system development and should assume responsibility for fulfilling this plan. The department should enhance the EMS section as necessary to adequately support trauma system activities for the State of Iowa.

The lead agency must integrate prehospital, hospital and all other system components while being responsive to the needs of both the providers and the public. The following organizational chart shows the trauma system lead agency and its relationship to other EMS agency components:



TRAUMA SYSTEMS ADVISORY COUNCIL

During the past three years, the Iowa Trauma Systems Development Consortium has brought together the key players in trauma care delivery in Iowa. This consortium will continue to advise the department until legislation establishes the Trauma System Advisory Council (TSAC). The TSAC will be under the lead agency providing the director and program staff with expert advice necessary for trauma system development and implementation of the components of this

trauma plan. Development of medical direction, standards of trauma care, treatment and triage protocols, trauma hospital categorization, trauma registries, patient advocacy and public education and prevention will be the priority responsibilities of the TSAC. The TSAC will work closely with the Iowa EMS Advisory Council. Membership will be appointed by the department director through recommendations from representative groups. Recommendations for TSAC membership include one person from each of the following:

Iowa Department of Public Health Trauma Coordinator

American College of Surgeons (Iowa Chapter)

American College of Emergency Physicians (Iowa Chapter)

Chairperson of the System Evaluation and Quality Improvement Committee (SEQIC)

Iowa Emergency Nurses Association

Iowa Hospital Association (Urban)

Iowa Hospital Association (Rural)

Iowa EMS Association

Iowa Medical Society

Iowa Osteopathic Medical Society

Iowa Governor's Traffic Safety Bureau

Iowa State Medical Examiner

Trauma Nurse Coordinator representing the Trauma Registry Hospitals

American Academy of Pediatrics (Iowa Chapter)

Rehabilitation Representative

State EMS Medical Director

Iowa Injury Prevention Center

SYSTEM EVALUATION AND QUALITY IMPROVEMENT COMMITTEE

The System Evaluation and Quality Improvement Committee (SEQIC) will be created as a separate multidisciplinary Committee. The primary responsibility of SEQIC will be to develop, implement and conduct trauma system evaluation and quality assessment/improvement (QA/QI). Safeguards will guarantee the confidentiality of the committee functions to protect paient, physician and hospital confidentiality. The committee will not be involved in the QA/QI process of individual hospitals unless asked to do so by the individual hospital or the QA/QI concern affects the trauma system as a whole. Membership will be appointed by the Department Director. Recommendations for SEQIC membership include:

Two Trauma Surgeons (Urban/Rural)

Two Emergency Physicians (Urban/Rural)

One Orthopedic Surgeon

One Neurologic Surgeon

Two Trauma Nurse Coordinators (Urban/Rural)

Two Emergency Nurses (Urban/Rural)

Two Prehospital Care Providers (Urban/Rural)

IDPH Trauma Coordinator

Iowa Foundation for Medical Care Representative

State EMS Medical Director

The SEQIC committee will elect a physician member to act as chairperson and represent the committee on the Trauma System Advisory Council.

TRAUMA SYSTEM MEDICAL DIRECTOR

The identification of a medical director is essential to ensure medical accountability, act as a system advocate, and provide medical credibility throughout system development. This director must be assisted by the TSAC and SEQIC that link trauma system resources to the needs of the injured to assure integration of trauma care policies and the EMSff rauma Care System.

Iowa does not have an EMS medical director at this time. To optimize the care of the critically ill and injured within the state EMS!frauma System, an EMS medical director position is recommended. Future legislation must enable IDPH to develop and fill this position. The medical director must have the authority to assure standards of care as defined by the State EMS and Trauma councils are observed. When the trauma system is fully implemented a trauma systems medical director, should be considered.

SYSTEM

DEVELOPM ENT

SYSTEM DEVELOPMENT

Development and establishment of a trauma system are a challenge requiring commitment from health care professionals and public policy makers. Trauma care represents a continuum that is best provided by an integrated system of injury prevention, acute care and rehabilitation requiring close cooperation among specialists in each phase of care. A systems approach to trauma care acknowledges this continuum and reduces costs, disability and death from life-threatening injury.

The Trauma Care System model recommended in the 1990 Trauma Care Systems and Development Act encourages the formation of an *inclusive trauma system* in which each care provider and facility is incorporated into the system. This model establishes a system that is fully integrated into the EMS system and serves to meet the needs of all injured patients requiring care in an acute care facility, regardless of severity of injury. It maintains that trauma centers are key clinical institutions in the system, but recognizes the need for health care facilities within the system to triage the severely injured for definitive care as appropriate.

The goal of a trauma system is to match the patient's needs to the existing resources so that optimal and cost-effective care is achieved. Trauma system development for the State of Iowa is geared to achieve this goal; in recognition of the unique needs of a predominant rural environment of the state.

TRAUMA SYSTEM PLANNING

Development of a trauma plan for the State of Iowa has been a topic of discussion for many years. As a result of grant funding from the Federal Health Resources Services Administration (HRSA) to the Iowa Department of Public Health for the Iowa Trauma Systems Development Project, the process of developing a trauma plan has taken on momentum.

Initially, grant funding from HRSA was dedicated to develop an emergency department based injury surveillance system for Iowa. This resulted in collaboration with the University oflowa in the Trauma Injury Surveillance Project (TISP) at 10 rural hospitals in northwest Iowa. Results from the TISP project are summarized in Appendix A.

During the spring and summer of 1994, the Iowa Trauma Systems Development Consortium developed a hospital trauma resource survey as a needs assessment tool for the identification of appropriate trauma care resources. Results from this survey identified the current statewide trauma care capabilities and resource distribution. The summary of findings from this survey can be found in Appendix B.

As a result of needs assessment and discussion over the past two years, the Iowa Trauma Systems Development Consortium has worked to develop and recommend this trauma plan for the State of Iowa, including the process of implementation and systematic review of the plan.

The next step in establishing a trauma system for the State of Iowa is to establish legal authority for the development of such a system. Legislation will be required to establish a lead agency with strong oversight and an advisory body composed of health care practitioners and public health representatives. The advisory body (TSAC) as discussed on page 7 and 8 of this plan must have the authority to provide ongoing review and recommendations for the trauma plan. The lead agency will assume responsibility for implementing the objectives of the plan.

The format for trauma plan implementation and approval must follow the usual rule making process. The lead agency will submit administrative rules for the trauma system, and through the process of public hearing these rules will be amended as necessary and then adopted. On at least an annual basis, the rules should be reviewed by the advisory council. Proposed changes will be subject to the rule making process.

Following the establishment of the lead agency, the Trauma System Advisory Council (TSAC) will develop and recommend criteria for optimal care to assure the trauma care system's success. Several nationally recognized guidelines exist which serve as models for system standards. They include standards from the American College of Surgeons, the American College of Emergency Physicians, and those published by the United States Department of Health and Human Services Public Health Service Health Resources and Services Administration (HRSA). Considering the unique needs and resources available within the State of Iowa, system-wide standards will be developed within one year of the Trauma System Advisory Council (TSAC) formation.

Inhospital care for the seriously injured is best provided by facilities whose governing bodies, administrations and medical staffs are committed with readily available resources to provide excellence in trauma care. Definitive treatment is best provided by specialists who are specifically trained in trauma care. To assure the trauma patient has prompt access to the necessary diagnostic and treatment resources, hospital facilities need to be categorized according to their trauma care capability. Criteria for hospital level of trauma care capability will be determined by the TSAC within one year of the council's formation.

In an inclusive trauma care system, all hospitals would ideally participate as a trauma facility according to their level of care capability and promptly triage severely injured patients to a higher level of care as necessary. Therefore, every hospital in Iowa should participate in the trauma system through the process of categorization/verification. Level I & II trauma centers are capable of managing all critically injured patients and generally exist in urban areas. Level III & IV trauma centers primarily exist in rural areas and are capable of initially managing all patients, but must rapidly stabilize and transport the critically injured to an appropriate level I or II facility if the case exceeds their capability. The inclusive trauma care system ensures coordination between all levels of trauma centers so that efficient and prompt interfacility communication and transfer can take place according to the patient's needs. The system requires trauma center availability throughout the state of Iowa and must ensure prompt transfer between facilities during all phases of acute and rehabilitative care.

TRAUMA SYSTEM OPERATIONS

The trauma system components including both hospital and prehospital training, triage, treatment, transport, transfer, medical direction, communication, rehabilitation , evaluation, prevention and public education must be integrated into the overall EMS system. The effectiveness of the trauma care system depends upon such integration. The lead agency responsible for trauma care should be under the same state departmental authority as the EMS system to assure the required integration.

The Trauma System Advisory Council (TSAC) will advise the lead agency to develop, maintain and revise all policies, procedures and protocols for trauma care within the trauma care system. The lead agency and the system medical director will be responsible to implement the policies as developed and to refer concerns to the TSAC for recommendation of any necessary changes to improve the trauma care system.

LEGISLATION

LEGISLATION

The need for enabling legislation to implement the *Iowa Trauma Plan* and to authorize the Department of Public Health to initiate systems development is evident. Development of an effective trauma system depends upon legislation which addresses the responsibility and authority of implementation. In order to facilitate the passage of trauma systems legislation, the Iowa Trauma Systems Development Consortium in cooperation with the Department of Public Health will launch a legislative initiative after final adoption of the Iowa Trauma Plan.

This legislative initiative will have three major components. The first is the drafting of the enabling legislation which authorizes the department to implement the *Iowa Trauma Plan.* The second component is the development of a coalition of consortium member organizations and other special interest groups supportive of trauma systems development. The focus of this effort will be to achieve consensus on the draft enabling legislation and to coordinate the legislative strategy. The final component of the legislative initiative is the public information and education campaign, the culmination of which is the Trauma Summit planned for December 1994. The goal of the campaign is to raise public awareness about the need for a coordinated trauma care delivery system. In addition, the campaign is designed to increase public support of the *Iowa Trauma Plan.* Individual legislators and key staff will take part in information sessions on the Iowa Trauma Plan and the proposed legislation.

The legislative education component is planned as on-going during the legislative session. Appendix C depicts the timeline for implementation of the trauma systems development legislative initiative.

Specific effort and attention will be focused on developing a coalition and other advocacy and special interest groups (such as the Iowa Head Injury Advisory Council). The purpose of this coalition is to unify their legislative influence towards a common goal of reduced morbidity, mortality and the costs associated with trauma injury. The support of such member organizations of the consortium as the Iowa Hospital Association, Iowa Medical Society, Iowa Nurses Association, Iowa Emergency Medical Services Association, Iowa Chapter of the American College of Surgeons, Iowa Chapter of the American College of Emergency Physicians and others is crucial.

Trauma legislation will be introduced by the Department of Public Health on behalf of the consortium and its member organizations. The content of the legislative proposal will be concise and enabling and reflect the policy decisions advanced in the *Iowa Trauma Plan.*

FINANCE

FINANCE

The cost of injury to society can be reduced by trauma care systems. A well designed trauma system has potential for substantial savings by reducing death and disability from traumatic 1Iljury.

An effective trauma care system is contingent upon the performance of each system component. Funds need to be available to support each component as follows:

Lead Agency

Legislative recognition should be secured regarding the need to fmancially support a lead agency to promote, coordinate, measure and evaluate the performance of the Iowa trauma system. Trauma system administrative costs include support for planning, hospital categorization, staffing system data collection and analysis, regulatory activities and preventive programs.

HoS.JJitals

Trauma care often represents a significant portion of unreimbursed care due to the high percentage of uninsured trauma patients and the high cost of providing such care. Hospitals categorized within the Iowa trauma system should be eligible for grants and /or low interest loans to meet Iowa Trauma System standards.

All COlllJilercial health insurance products sold in Iowa should provide for reasonable coverage of all phases and aspects of trauma care as determined by the Iowa trauma system planning process in consultation with the Iowa Insurance Commission, business and labor groups, and trauma care providers.

Phvsicians

The economic impact of trauma care on physician practices needs to be evaluated. The cost of physician services within the trauma system should be recognized and factored into a revenue stream for physicians and/or hospitals. Effective economic incentives must be present to cover the costs for caring for trauma patients.

Pre-hospital EMS providers

Efforts should be made to establish parity between the cost of delivering pre-hospital EMS services and the fee schedules for recovering these costs. Consideration should be given to a methodology that reflects a balance between workload volumes, fixed expenses, level of service provided, type of service and staffing configurations. Current funding sources for training and equipment should be targeted to meet the training and equipment needs of the trauma patient during system development.

A prehospital fee structure needs to be established that recognizes the "hidden costs" associated with volunteer staffing configurations. This structure will reflect trends to move toward a paid staff arrangement as population increases and/or the availability of volunteers decreases.

FUNDING MECHANISM

A dedicated funding mechanism is necessary to provide fiscal support at all levels of the trauma care system. Proposed legislation will authorize dedicated revenue support and consider fees such as telephone surcharges, taxes on cigarettes or alcohol, surcharges on motor vehicle registration, traffic violation penalties, and taxes on sales of weapons or use permits.

Health care reform needs to address concerns related to trauma care. These include incentives built into insurance vehicles to reinforce the importance of health safety and injury prevention behaviors.

It is imperative that legislators and consumers understand the significance of an effective trauma care system in decreasing the overall incidence of injury and the related burden of cost to society. However, such a system relies heavily upon maintaining trauma care services and facilities in a ready state. Such trauma care preparations require long-term financial planning and support.

PUBLIC

INFORMATION / EDUCATION

AND

PREVENTION

PUBLIC INFORMATION/EDUCATION AND PREVENTION

The ultimate goal of an organized trauma system is to prevent disability and death due to injury. Public information/education must serve to enhance the public's ability to make health safety choices for injury prevention. Also, when emergency care is necessary due to injury occurrence, the public must have knowledge on how to access the EMS System.

Under the direction of the state lead agency, public information/education and prevention activities will be coordinated using resources at the local, county, regional and state levels for information/data gathering, documenting the need for prevention efforts, developing program goals and assisting in identifying resources for program implementation.

The public information/education and prevention aspects of the Iowa trauma system will include the following:

1) Heightened public awareness of injury as a preventable public health problem and the need for and definition of a trauma care system.
2) How to access the EMS system.
3) Promote education programs to inform the public about what to do before EMS help arrives.
4) Provide education programs that stress prevention as a key focus to reduce many types of traumatic incidents.

5) Serve as a clearing house for existing data resources, prevention activities and trauma related organizations within the state.

6) Coordinate existing EMSff rauma public information/education and prevention efforts throughout Iowa to better maximize the impact of these programs.

7) Assess public knowledge of EMSff rauma and its benefits to public health of Iowa citizens.

8) To complete the goals of a public information/education and prevention activities, the lead agency will work with the Department Public Information Officer for the purpose of coordination, production and provision of EMSff rauma prevention programs.

HUMAN RESOURCES

HUMAN RESOURCES

IOWA DEPARTMENT OF PUBLIC HEALTH

The following are recommended to staff a state trauma system:

1) Trauma Program Coordinator

2) Medical Director EMS/Trauma System

3) Secretarial Support

4) Trauma Registry Coordinator

5) Computer Analyst

6) Injury Prevention Coordinator

CURRENT WORKFORCE RECOURCES

Current statistics show a relatively adequate number of health care providers but inadequate distribution of them (See APPENDIX D). Retention of health care providers in Iowa is critical. Innovative programs designed to motivate the experienced provider and new providers are available and needed. These resources will be made available to each community providing mJury care.

Level I and Level II facilities will need to consider the following resources:

1. Trauma Nurse Coordinator
2. Chart abstractor
3. Secretarial Support

The accuracy and completeness of injury data accumulated and reported will be reflective of availability of support and resources.

TRAUMA CARE EDUCATION

Comprehensive trauma education should include aff health care providers involved in the continum of trauma care as well as the lay public. Trauma courses that meet the needs of all health care providers and bystanders should be developed. Trauma course objectives should include primary and secondary assessment and resuscitation with triage decision-making presented. Telemedicine via fiberoptics can and has made education more accessible inthe rural areas.

The following are funding recommendations for continuing education:

- Adequate funding for all trauma training programs.
- Provisions for funding such alternative learning models as computer-managed instruction, interactive videos and discs.
- Iowa should continue to make training funds available on a reimbursement basis for Iowa EMS providers.

PREHOSPITAL CARE

PREHOSPITAL CARE

Prehospital emergency medical services (EMS) is a coordinated effort of trained personnel and resources that stands readily available to respond to medical emergencies. The goal of prehospital EMS is to reduce suffering, disability and death from life threatening injury and illness.

Prehospital emergency care is a vital part of a trauma system. The prehospital components of a trauma system will provide easy access and appropriate field intervention for the critically injured. What happens in this setting often influences the patient's final outcome. Management of the severely injured patient begins with evaluation and treatment at the scene by prehospital emergency care providers. To achieve the best possible outcome, prehospital stabilization must be done in a minimal amount of time; stabilization requires an assessment, extrication, initiation of resuscitation, and rapid transportation to the nearest *appropriate* hospital.

It is essential that medical control is available to guide patient care. This includes physician involvement with development of policies, procedures and protocols for training, triage, treatment, transport and transfer of injured patients. The quality improvement process, regular review of the process and outcome of patient care, allows for feedback to providers and managers about patient care success and areas needing change.

COMMUNICATION

Communication systems provide essential coordination among the components of the EMS and trauma care system. Easy access to the system through a single coordinated 9-1-1 system should be available at all locations. Public information and education programs should address EMS system access and importance of rapid intervention for the seriously injured.

Emergency medical dispatchers should complete an approved standardized medical dispatcher education course to prepare them to provide the most appropriate EMS response. The dispatch center should provide call screening and questioning to match the injured person's needs with existing EMS resources. Pre-arrival instructions should be offered to callers according to protocols.

There should be a quality improvement program for all communication equipment with monitors to measure system demand, peer review of staff performance, preventative maintenance and new equipment checks, an4 incident control monitors. Periodic revision of communication policies and procedures should be performed to maintain the most efficient and effective medical dispatch program.

MEDICAL DIRECTION

EMS System medical direction seeks to assure appropriateness of all medical aspects of the prehospital program and is an essential component of prehospital trauma care. Physician involvement is required for the design, implementation, continual revision and operation of the trauma system from earliest prehospital contact through delivery of definitive care. All training of emergency medical personnel, including course design, supervision of training, continuing education, ongoing performance evaluation through audit review and critique sessions, and other appropriate components must be under the direction of a physician.

Physician medical control of prehospital emergency care may be accomplished through direct voice communication (on-line) with prehospital emergency personnel or through provision of care in accordance with patient care protocols developed and promulgated by physicians (off-line), and physician supervised quality improvement activities. Every prehospital ambulance or rescue service should have an identifiable medical director who is responsible for all aspects of indirect medical control (off-line) of that service. Changes in the current Advanced Care Act (Iowa Law Chapter 147-A) should be considered to include all basic care services in Iowa to assure medical accountability at all levels of care delivery.

To optimize medical control of all prehospital emergency medical services, the physician medical director must be knowledgeable about the care of the critically ill and injured patients.

Individual service physician medical directors should meet the following requirements:

1. Familiarity with the design and operation of prehospital EMS systems
2. Experience in prehospital emergency care of the acutely ill or injured patient
3. Experience in base-station radio control of prehospital emergency units
4. Experience in emergency department management of the acutely ill or injured patient
5. Involvement in the training of prehospital personnel
6. Involvement in the medical audit, review and critique of prehospital personnel

The EMS system medical director should be a physician who meets the above requirements and is also knowledgeable in trauma system planning. This physician must have a well-defined position with respect to the EMS!frauma system and have the authority to develop the necessary clinical standards and subsequent policies and procedures that assure that these standards of care are observed.

Quality improvement is an essential function of medical control. Medical audit and review of care can be handled by committees functioning under the medical director with representation from appropriate EMS, medical, nursing and other health care professions.

Methods to review care may include:

1) Concurrent case review at the on-line agency;
2) Retrospective case review conferences;
   -appropriateness of assessment
   -compliance with treatment protocols
   -appropriate utilization of on-line medical control
   -improvement in patient status
3) In-house experiences for prehospital personnel;
4) Skills maintenance log;
5) Medical audit of calls;
6) Direct observation of field performance;
7) Review of morbidity and mortality rates and outcome criteria for trends.

Physician designees authorized to provide on-line medical control should complete a course with a standardized curriculum. All functions of physician designees should be reviewed by the medical director to assure appropriate involvement with prehospital care.

TRIAGE

Triage is the process of sorting injured patient(s) by actual or perceived degree or risk of injury and assigning them to the most appropriate regional care resources. The purpose is to provide optimal care with maximum efficiency and minimal cost in terms of live.s saved, disability and expenditure of funds. Resources must be organized and utilized using a systems approach for the rapid decisions required during the initial treatment of trauma patients.

Identification of the major trauma patient is fundamental to trauma system design because it describes the patient who will benefit the most from regionalized care. Triage of such patients to the appropriate medical facility determines the level and intensity of resources needed to provide definitive care. 1Jie following criteria define categories for assisting with triage of the major trauma patient:

I) Multisystem blunt or penetrating trauma with unstable vital signs (physiologic)

2) Known or suspected severe injury (anatomic)

3) High energy event with probability of serious injury (mechanism)

Once the major trauma patient is identified the EMS system should activate an appropriate response system'. Field triage identifies those patients needing transport to the most appropriate Level I or II trauma hospitals rather than the nearest hospital. When scene or transport time for the critically injured paient exceeds 30 minutes, consideration of air transport must be given. Field personnel should always seek guidance from on-line medical direction if there is any doubt regarding triage treatment and transport decisions.

Both the available level of hospital resources and time/distance factors must be considered in making triage and destination decisions. Level III and IV trauma hospitals should serve patients who require initial stabilization and rapid transfer to the next highest level of care, and for patients that can he safely held for further evaluation and care. Level I and Il trauma hospitals

should serve patients who require a full trauma team approach and readily available diagnostic/intervention resources and specialty consultation.

Mass casualty triage is necessary when the need for emergency services exceeds the resources of any component of the system, prehospital or hospital. Each component providing care, prehospital and hospital, must have a plan that addresses multiple mass casualty occurrences which might overwhelm the resources. Such plans must be tested, evaluated and improvementS made on at least a yearly basis.

All triage guidelines and protocols must be combined with a quality improvement program and research to assure optimal and cost-effective care is being provided. Triage protocols must be refined to assure sensitivity to identify the moderately to severely injured patient, yet specific enough not to overburden the Level I & II hospital trauma facilities while utilizing existing resources.

TRANSPORT

Trauma patients should be delivered in a timely fashion to appropriate facilities utilizing the most expedient and appropriate means of transport. The failure of any component or coordination between components involved in care can result in significant delays to the detriment of the patient.

Factors to be considered in the development of transport protocols include population density, geography, ambulance resources available (ground/air), hospital capabilities, and location within a given area. A balance must be achieved between the economics of EMS availability and

utiliz.ation , actual demand, and patient care requirements. The dispatch system must continually evciluate and adjust itself to provide an appropriate and timely response to all patients, after first meeting response time criteria and utiliz.ation criteria for rural areas.

Particularly in rural areas the time to definitive care can be reduced by bringing air ambulances with higher skill level resources directly to the patient, thus decreasing transport time and possible geographic barriers. In urban areas air ambulances can reduce transport time due to external or environmental factors (weather, traffic congestion and geographic barriers) in cases which transport time by ground would be excessive. If available, air transport should be used when the time to extricate and transport the severely injured person exceeds 30 minutes, or when higher skill level of care would benefit the patient.

DEFINITIVE CARE

DEFINITIVE CARE

It is imperative that injured patients are delivered in a timely manner to the closest appropriate facility. The trauma care system is a network for definitive care involving facilities that provide a spectrum of care for all injured patients. Standards for trauma facilities and categorization levels will be established based on the most current guidelines published by the American College of Surgeons Committee on Trauma *"Resourcesfor the Optimal Care of the Injured Patient",* the American College of Emergency Physicians *"Guidelinesfor Trauma Care Systems"* and Health Resource and Services Administration (HRSA) *"Model Trauma Care Plan".*

It is the goal of the *Iowa Trauma Plan* to enable all acute care facilities to participate in the inclusive trauma system. The trauma plan should integrate all facilities into an inclusive network in order to provide a full spectrum of definitive care for all injured patients throughout the state of Iowa.

TRAUMA CARE FACILITIES

Level I

The Level I facility is a regional resource trauma center that is a tertiary care facility central to the trauma care system. A Level I facility must have the capability of providing leadership and total care for every aspect of injury, from prevention through rehabilitation. In its central role, the Level I center must have adequate depth of resources and personnel.

In addition to acute care responsibilities, Level I trauma centers have the major responsibility of providing leadership in education, research, and system planning. This responsibility extends to all hospitals caring for injured patients in their region.

Medical education programs include postgraduate training in trauma for physicians, nurses, and prehospital providers. Education can be accomplished through a variety of mechanisms, including classic continuing medical education (CME), preceptorships, personnel exchanges, and other approaches appropriate to the local situation. Research and prevention programs are essential for a Level I trauma center.

Level II

The Level II facility is a hospital that is also expected to provide initial definitive trauma care regardless of the severity of injury. Depending on geographic location, patient volume, personnel, and resources, however, the Level II facility may not be able to provide the same comprehensive care as a Level I facility. Therefore, patients with more complex injuries may have to be transferred to a Level I facility. Level II facilities may be the most prevalent facility in a community, managing the majority of the trauma patients.

Educational outreach, research, and prevention programs are similar to those required of a Level I facility. However, research is not an essential criterion for a Level II center. In areas where a Level I facility is remote, the Level II center should take on the responsibility for education and system leadership.

Level III

Level III facilities can provide prompt assessment, resuscitation, emergency operations, and stabilization. When appropriate, Level III facilities promptly arrange for transfer to a facility that can provide definitive trauma care. Prompt availability of general surgeons is required in a Level III facility. Planning for care of injured patients in these hospitals requires transfer agreements and standardized treatment protocols.

Leve/ IV

Level IV trauma facilities provide advanced trauma life support prior to patient transfer in from remote areas where no higher level of care is available. Such a facility may be a clinic rather than a hospital and may or may not have a physician available. The level IV facility should be an integral part of the inclusive trauma system. Standardized treatment protocols for resuscitation, transfer protocols, data reporting and participation in system quality improvement are necessary. Funding mech anisms for non hospital Level IV facilities need to be secured to insure adequate reimbursement. A Level IV trauma facility should have a good working relationship with the nearest Level I, II, or III facility. This relationship is vital to the development of a rural trauma system in which realistic standards must be based on available resources.

Specialized Care

Specialized trauma care must be provided by personnel and facilities with a special interest and competence in care of the specialized injured patient. Burn, spinal cord, eye injury and limb replantation are examples of clinical problems that demand highly specialized care, facilities, training and organization of specialty teams. Effective transfer agreements and protocols must

be developed for all specialized facilities. Rehabilitation centers must also be integrated into the trauma system. It is vital to involve physical medicine rehabilitation as soon as possible in the acute care setting and later, upon discharge, into the rehabilitative phase.

CATEGORIZATION / VERIFICATION PROCESS

The lead agency in the trauma system will utilize criteria pending development by the Trauma System Advisory Committee (TSAC) to classify each facility according to their commitment to trauma as measured by their resources and personnel. This would be an inclusive system which acknowledges each facility as having a role to play in the optimal care of the trauma patient, recognizing that trauma patients will present for care at all hospitals in Iowa.

The process of categorization would begin with each health care facility being sent a categorization checklist. This checklist would be completed by the facility and returned to the lead agency for verification. Upon receipt of the completed checklist the lead agency would then make arrangements for verification/certification. Facilities would then be required to complete the TSAC recommended verification process by the lead agency. The lead agency would determine compliance to the resource capability checklist and issue a certificate of verification for a level of care capability as determined by the process.

The evaluation process for categorized facilities should address routine medical care evaluations and provider compliance with contractual obligations. Through the trauma registry, the system can be studied to improve patient care and ensure compliance with accepted standards of care.

There should be a mechanism for a periodic review of the categorized facilities, with a clear process for recategorization / verification.

INTRAFACILITY TRANSFER

Central to an inclusive system, hospitals must be able to transfer patients rapidly and effectively between trauma facilities when necessary to provide higher level of care and return of the less critically injured as their condition warrants. This process will free up beds from crowded higher level facilities, encourage sharing of clinical expertise between hospitals and place patients closer to their homes. Formal letters of agreement should be obtained attesting to the willingness of hospitals to facilitate the rapid and unobstructed transfer of patients as necessary and indicated. These transfer agreements must be consistent with current COBRA regulations.

EVALUATION

EVALUATION

Trauma system evaluation is achieved through a comprehensive quality improvement (QI) program. The purpose of the system QI program is to review system performance as related to patient needs, system resources, medical care and costs. Trends in care and outcome must be identified and appropriate system adjustments made to improve the quality and timely availability of trauma patient care.

As trauma care facilities and systems develop it is essential that ongoing assessment and reevaluation of the care and outcome of trauma patients occurs within a well defined QI program. Ongoing evaluation of the trauma care system is essential throughout the continuum of patient care.

To deliver the best possible care for the injured patients, both system and individual facilities must develop evaluation programs. There must be close cooperation between these programs. System QI must evaluate management of the overall trauma care system including prehospital care, hospital care and rehabilitation. Individual patient care should be monitored within the facility based QI program which is essential to specific case management and the ongoing development of individual institutions.

SYST,:M QUALITY IMPROVEMENT

The Iowa Department of Public Health, as the lead agency responsible for the system quality improvement program, will establish an inclusive data collection system that can track and evaluate the system's response for all injured patients.

A System Evaliiation and Quality Improvement Committee (SEQIC), as discussed on page 9 of this plan, will provide medical guidance and system oversight to the Iowa Department of Public Health. This medical audit committee should meet on a regular basis as determined by the Department to provide system data analysis, conduct regular on-going peer review of all disciplines, encourage positive system changes, translate system deficiencies into corrective action and enhance overall system performance.

System quality improvement will address comprehensive injury care including prevention, prehospital care, trauma facility and rehabilitation. Determination of clusters of injuries, high risk groups and populations will allow for more focused prevention programs. Patient outcomes should be based on a standard method of outcome evaluation (i.e. TRISS, RTS, Z values). Evaluation of patient outcomes will provide a basis for changes in education, process of care, protocols and treatment standardization. System evaluation information must be given back to providers to facilitate changes within and improve patient outcomes.

TRAUMA FACILITY QUALITY IMPROVEMENT

The goals of trauma facility quality improvement programs are to monitor the process and outcome of patient care, to insure the quality and timely provision of such care, to improve the knowledge and skills of trauma care providers, and to provide the institutional structure and organization to promote quality improvement.

All hospitals categorized within the Iowa Trauma System should work toward designing and implementing an effective quality improvement program that takes a systematic approach with the following elements as guidelines:

1. A hospital orga:niz.ational structure that facilitates the process of quality improvement.
2. The development of quality care standards.
3. A process for monitoring compliance with or adherence to the trauma system standards including the use of Trauma Score/Injury Severity Score (TRISS) methods for patient outcomes.
4. A process for peer review to evaluate specific cases or problems identified by the monitoring process.
5. A process for implementing corrective action to address problems or deficiencies identified by either the monitoring process or the peer-review process.
6. A process for reevaluating and documenting the effect of the corrective action taken.

For facilities categorized as Level III and IV, it is recommended that the focus be on indicators that are relevant to their setting such as time spent in resuscitation, time elapsed before decision to transfer, or type of diagnostic studies performed in the initial evaluation of trauma patients. Level I and II categorized facilities should work with level III and IV facilities in providing a quality improvement program.

The governing body of the hospital has the ultimate authority and responsibility to provide for the delivery of quality patient care. The care of the injured patient must be monitored and evaluated. All pertinent findings arising from this evaluation should be reported through channels that ultimately lead to the governing body.

RESEARCH

Ongoing systems research is necessary to guarantee the perpetual study, redirection and improvement of trauma system design, and ultimately, trauma patient outcome. It is important that research be used to validate the cost effectiveness of trauma care in both rural and urban settings.

Data submitted by hospitals will provide data to the brain and spinal cord injury registry, SPRAINS farm and agricultural registry and assist in injury prevention activities, research epidemiology and program evaluation.

The Iowa Department of Public Health may approve requests for data and other information from the registry for special studies and analyses, consistent with requirements for confidentiality of patient and quality assurance records. The release of confidential information shall be governed by the provisions of current laws regarding disclosure of personal records.

DATA COLLECTION

The Iowa Department of Public Health, with assistance from the Trauma System Advisory Council, should establish a state-wide data registry to collect and analyze the incidence, severity, and causes of injury for the purpose of:

(a) Monitoring and providing information necessary to evaluate injured patient care and outcome;

(b) Assessing compliance of prehospital providers, health care facilities, hospitals and rehabilitation services with the standards of state trauma system operation and categorization;

(c) Provide information necessary for resource planning and management;

(d) Provide data for injury surveillance, analysis, and prevention programs;

(e) Provide a resource for research and education.

Patients included in the injury registry should be reported by:

(a) All authorized prehospital providers;

(b) Health care facilities, both categorized and noncategorized;

(c) Injury rehabilitation services;

(d) Medical examiners;

(e) Sources outside the trauma system which may include but not be limited to:

1) Death certificates

2) Fire Incident Reporting System

3) Community Health Management Information System (CHMIS)

4) Traffic Safety Records

Data elements to be submitted should provide information in the following categories:

(a) Demographic;

(b) Anatomic;

(c) Physiologic;

(d) Severity;

(e) Epidemiological;

(f) Resource utilization;

(g) Quality assurance;

(h) Outcome; and

(I) Financial

The data registries should work toward a case specific patient identifier common to all data sources in order to enhance linkage capabilities.

The Iowa Department of Public Health should provide procedures for electronic transfer and submission of data including specifications for necessary software; or provide forms for manual submission of data.

The Iowa Department of Public Health should develop detailed protocols for quality control, perform validation studies for completeness and accuracy of submitted data and provide a report to each provider submitting data.

A pilot of the data collection system should completed by July 1996, which assesses the impact of data reporting on hospital and prehospital participants, and evaluates the appropriateness of the inclusion criteria and required data elements.

The recommended minimum core data registries to be included in the Iowa Trauma System are:

1. Prehospital system registry
2. Emergency Department Registry
3. Hospital System Registry

Trauma System data can augment a statewide injury surveillance system when combined with vital statistics, mortality data and other data sources.

Prehosoital System Registry

The Iowa Department of Public Health, Emergency Medical Services Section, should maintain a prehospital system registry to collect data from injured patients treated by prehospital personnel. It should be the responsibility of all prehospital care providers to submit the required data to the Department. The data to be collected and reported to the Department should be determined by the Department with assistance from the Trauma System Advisory Council and as a minimum include the minimum prehospital data set. The department should establish a reporting mechanism to provide the prehospital providers with information resulting from the data collected.

Emergency Deoartment Registry

The Iowa Department of Public Health, Emergency Medical Services Section, should maintain an emergency department system registry to collect data from injured patients treated in the emergency department. It should be the responsibility of all verified trauma facilities to report required data to the department. The data to be collected and reported to the department should be determined by the Department with assistance from the Trauma System Advisory Council and include the minimum emergency department data set. The Department should establish a reporting mechanism to provide the categorized facilities with information resulting from the data collected.

Hosvital SJistem Registry

The Iowa Department of Public Health, Emergency Medical Services Section, should maintain a hospital system registry to collect data from acute injured patients. All facilities verified at Level I and II should be required to report the trauma registry data set. The data to be collected and reported to the department should be determined by the department with assistance from the Trauma System Advisory Council and as a minimum include the minimum system data set.

The Department should establish a reporting mechanism to provide the categorized facilities with information resulting from the data collected.

Inclusion Criteria

Authorized prehospital care providers should submit the required data for injured patients that are :

a. dead at the scene; and

b. all injured patients who are transported to a health care facility

Emerency departments in categorized trauma facilities should report all treated injured patients for ICD-9's 800 through 959.

The population to be included in all level I and II facilities hospital system registry data element reporting are:

a. injured patients who die;

b. injured patients who are admitted to the hospital for a stay greater than 24 hours;

c. injured patients who are admitted to intensive care units or an operating room;

d. injured patients who are transferred into or out of the hospital;

e. injured patients who are readmitted within 72 hours after discharge form the initial injury

Data should arrive at the department in an approved format no later than 90 days after the end of the quarter. Definitions of all data elements will be the responsibility of the Iowa Department of Public Health as recommended by the TSAC.

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ABBREVIATIONS

ATLS: Advanced Trauma Life Support

BTLS: Basic Trauma Life Support

CHMIS: Community Health Management Information System

CME: Continuing Medical Education

ED: Emergency Department

EMT: Emergency Medical Technician

EMS: Emergency Medical Service

HRSA: Health Resources and Services Administration

ICD-9: Ninth edition of the International Classification of Diseases Coding System

IDPH: Iowa Department of Public Health

PHTLS: Prehospital Trauma Life Support

PI & E: Public Information and Education

RISS: Rural Injury Surveillance System

RTS: Revised Trauma Score

SEQIC: System Evaluation and Quality Improvement Committee

SPRAINS: Sentinel Project Researching Agriculture Injury Notification System

TNCC: Trauma Nurse Core Course

TRISS: Trauma Score / Injury Severity Score

TSAC: Trauma System Advisory Council

QA: Quality Assurance

QI: Quality Improvement

Z: Statistic of outcome comparrison between two subsets

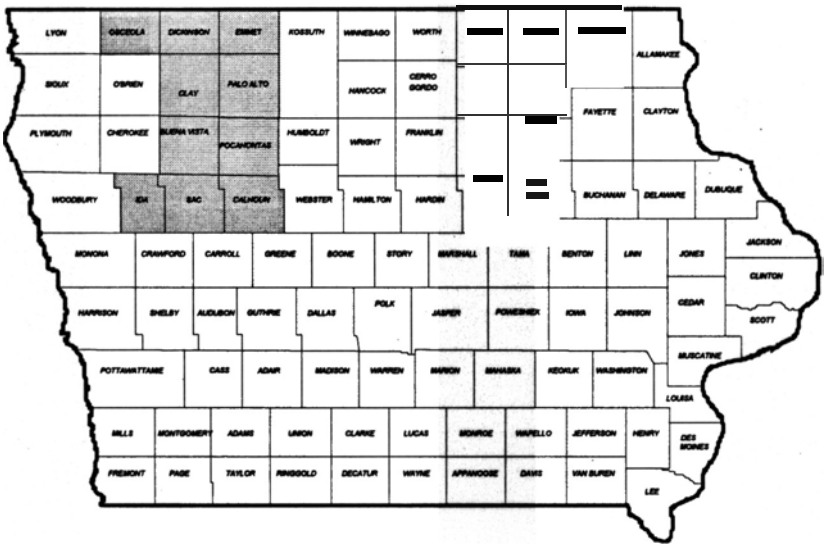
APPENDIX

APPENDIX A

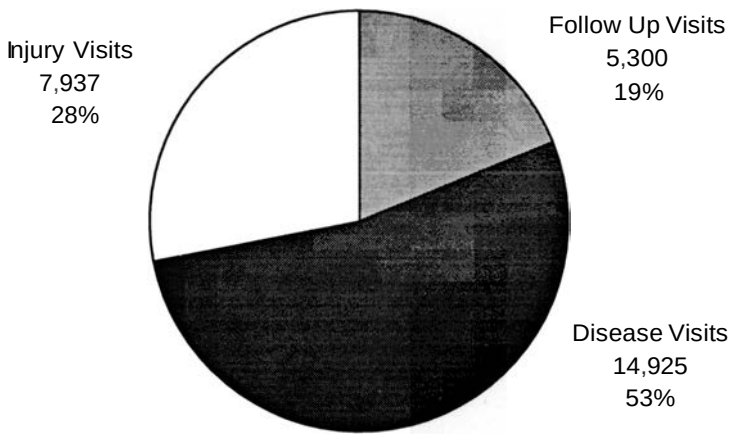
TRAUMA INJURY SURVEILLANCE PROJECT
Northwest Iowa - 9 Rural Hospitals
All Emergency Department Visits
July 1993 - June 1994

All Data Collected Using the RISS Software
(Rural Injury .Surveillance System)

County Map of Iowa (shaded counties are part of Trauma Injury Surveillance Project)



TYPE OF VISIT (28,162 Total Visits)



SUMMARY OF 7,937 INJURY VISITS

Patient Demographics

Male	58%
Female	42%
White	96%
Non-White	4%

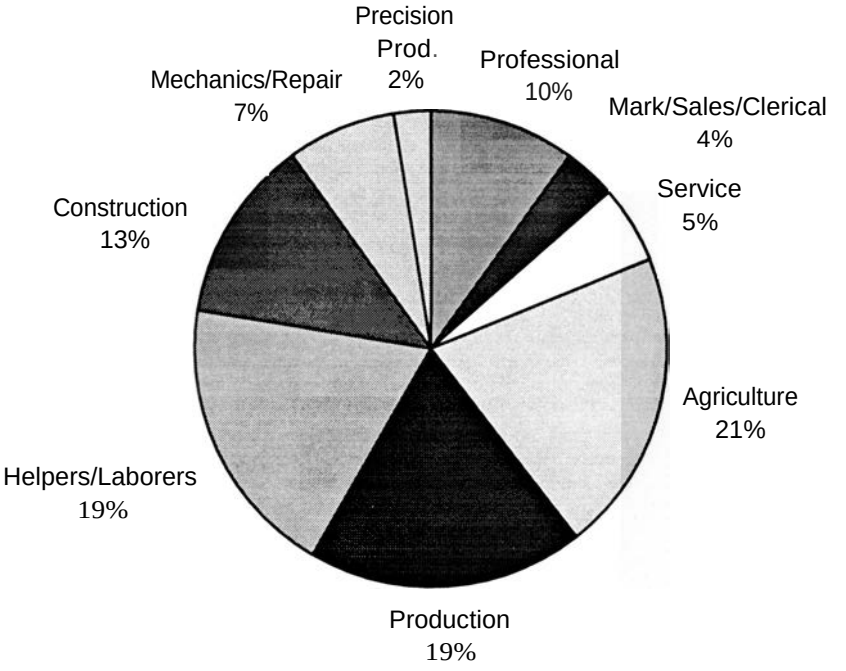
Age

4 Years & Under	8%
5-14 Years	18%
15-19 Years	14%
20-44 Years	34%
45-64 Years	11%
65 Years & Older	15%

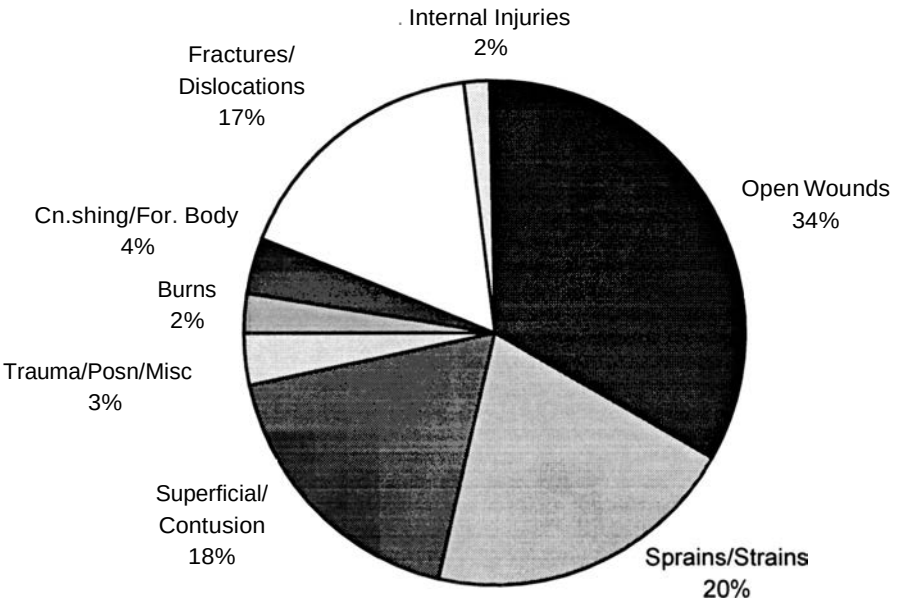
Nature of Injury

Work Related	12%
Farm Related	3.3%
Brain/Spinal Cord	.7%
Intentional	2.4%

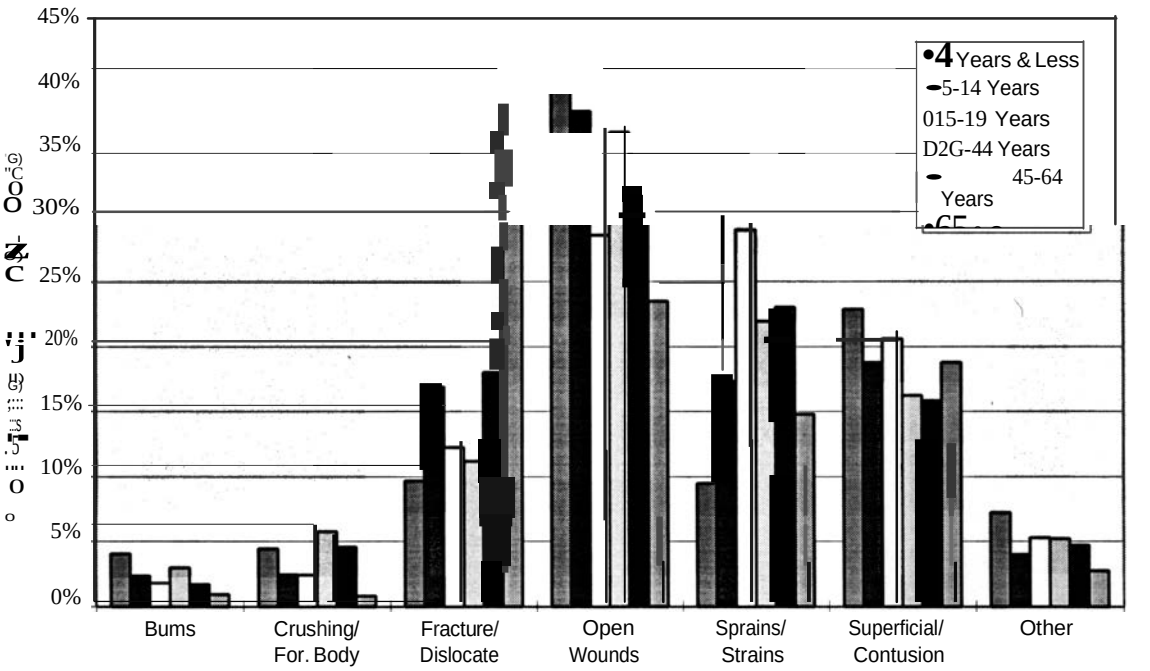
OCCUPATIONS OF PATIENTS WITH WORK RELATED INJURIES



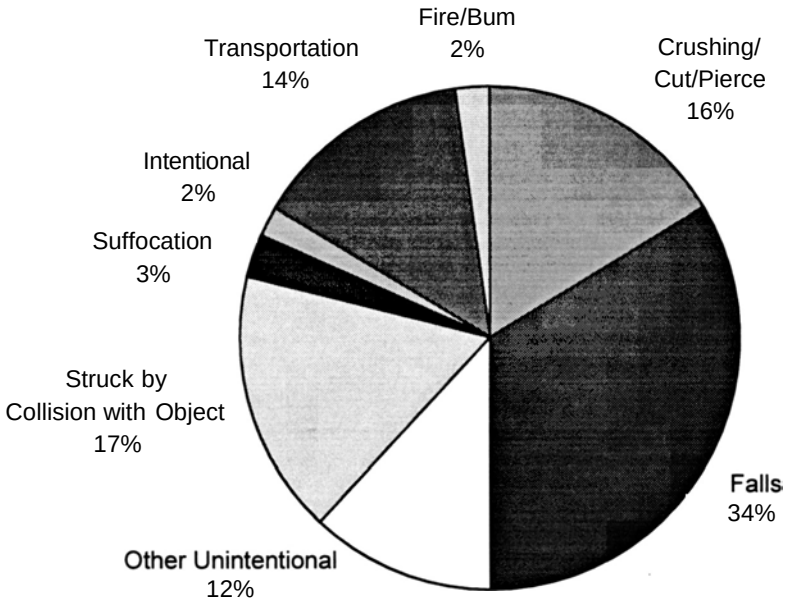
ICD9 N-CODES



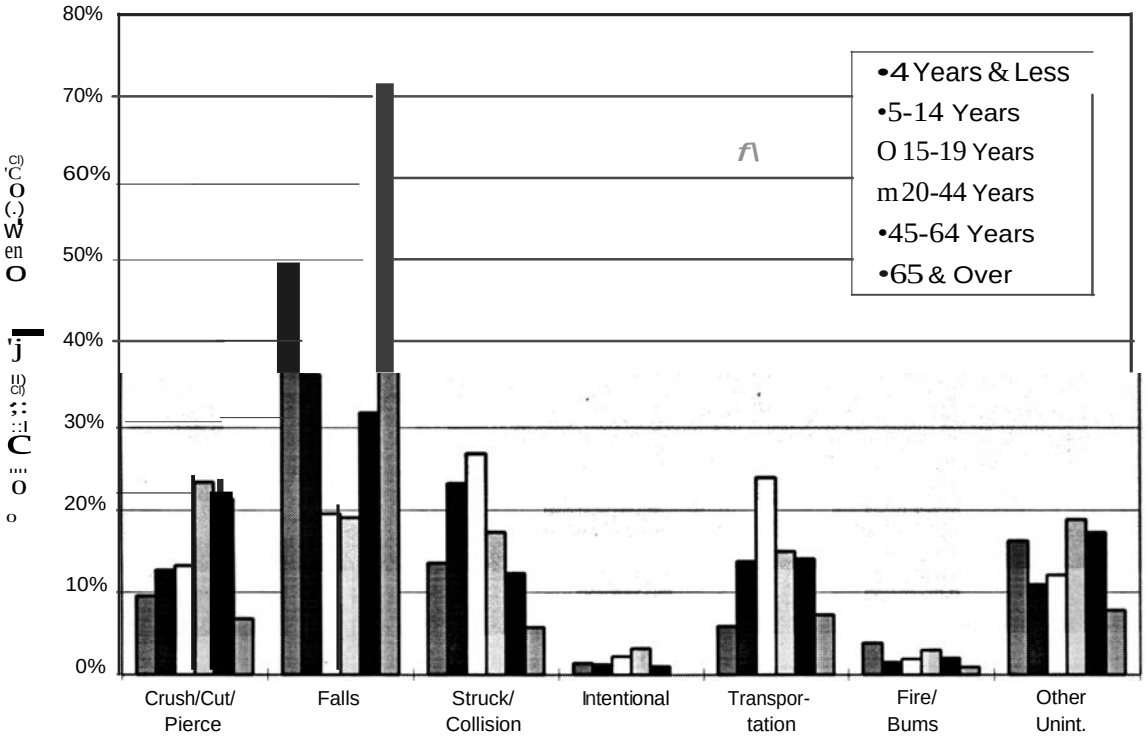
DISTRIBUTION OF ICD9 N-CODES FOR EACH AGE GROUP



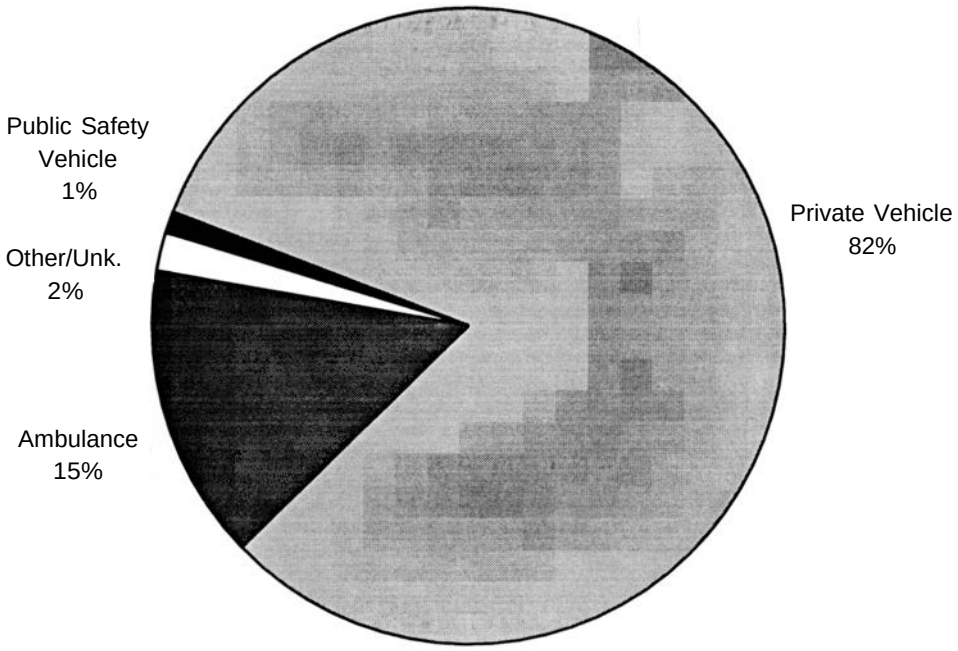
ICD9 E-CODES



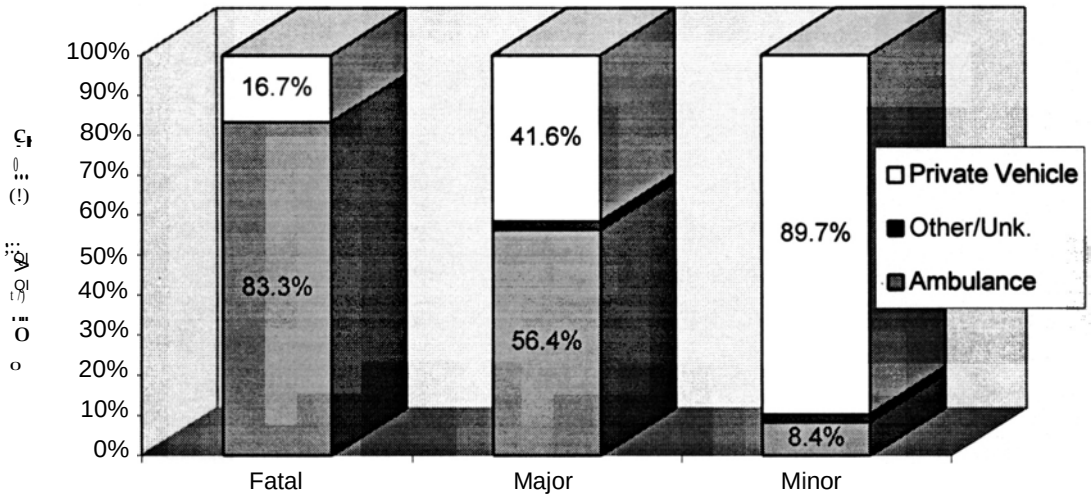
DISTRIBUTION OF ICD9 E-CODES FOR EACH AGE GROUP



MODE OF ARRIVAL



ob OF SEVERITY GROUP HAVING EACH MODE OF ARRIVAL



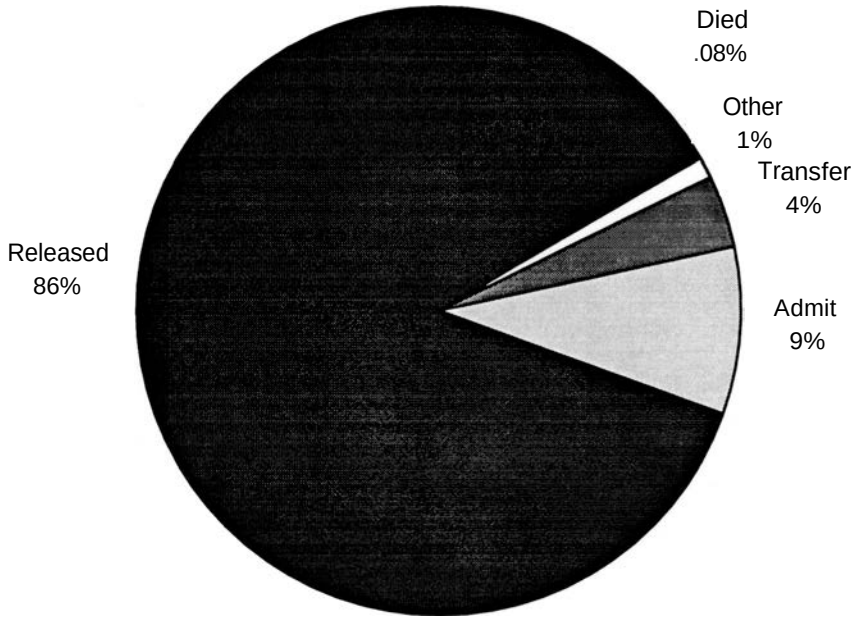
Severity Definitions:

Fatal Injury : Disposition = DOA/Died in ER

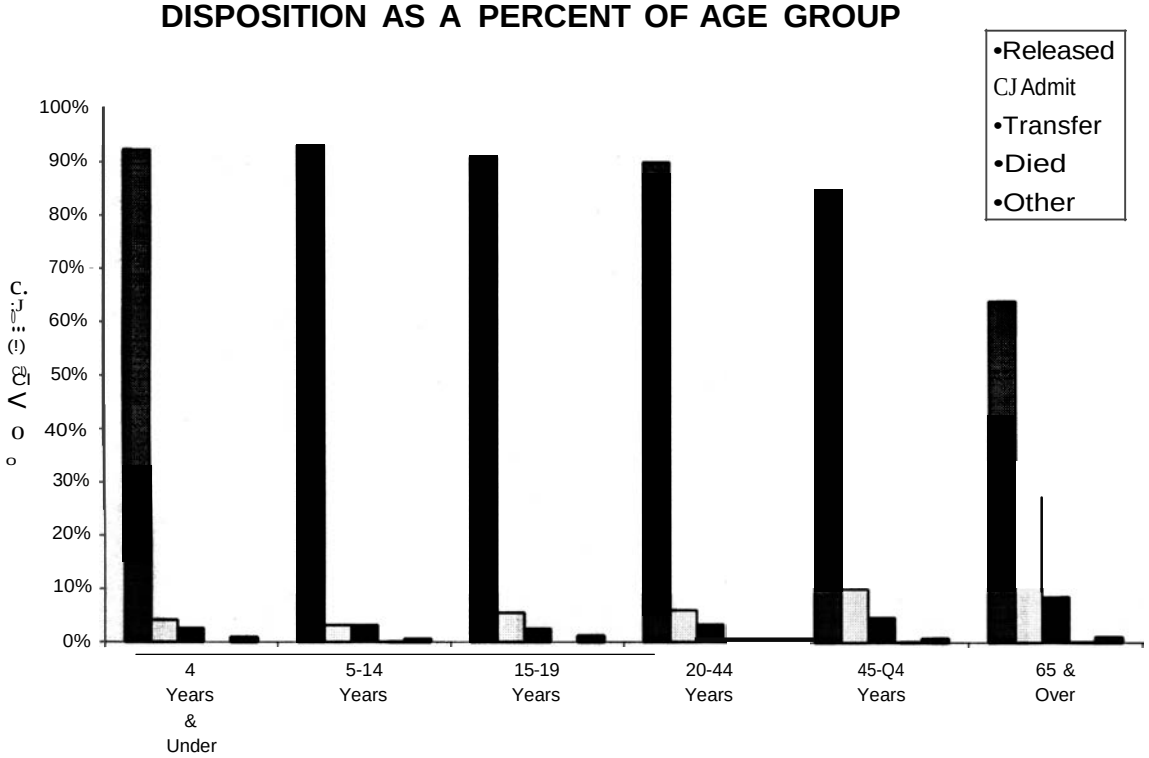
Major Injury : Disposition = Admit or Transfer
or GCS < 13 or SYS BP < 90 or Respitory Rate < 10 or > 29

Minor Injury : All Others

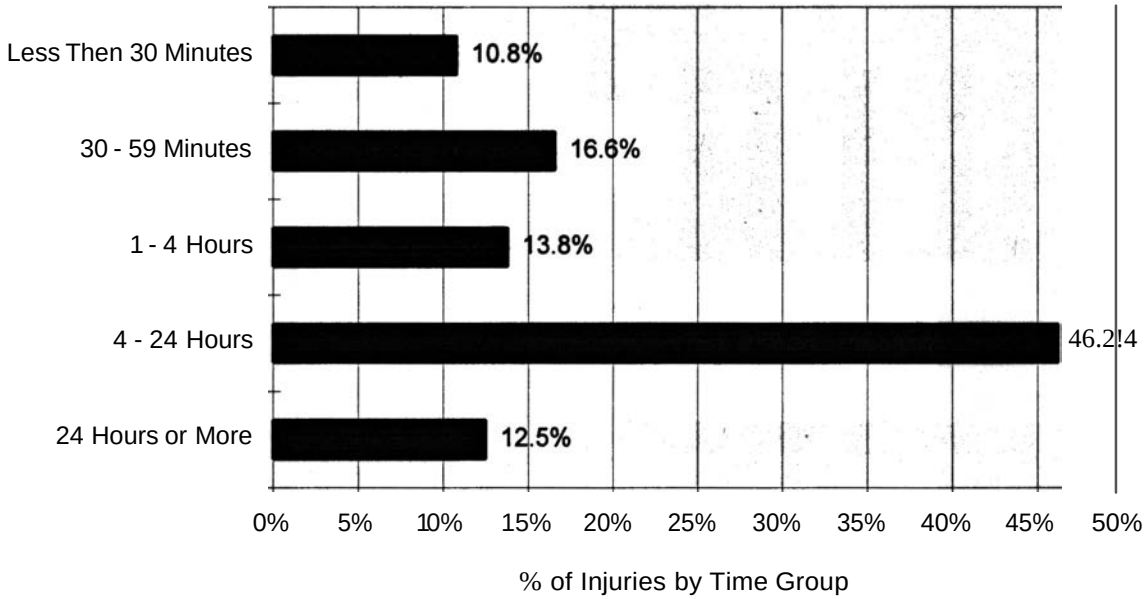
DISPOSITION



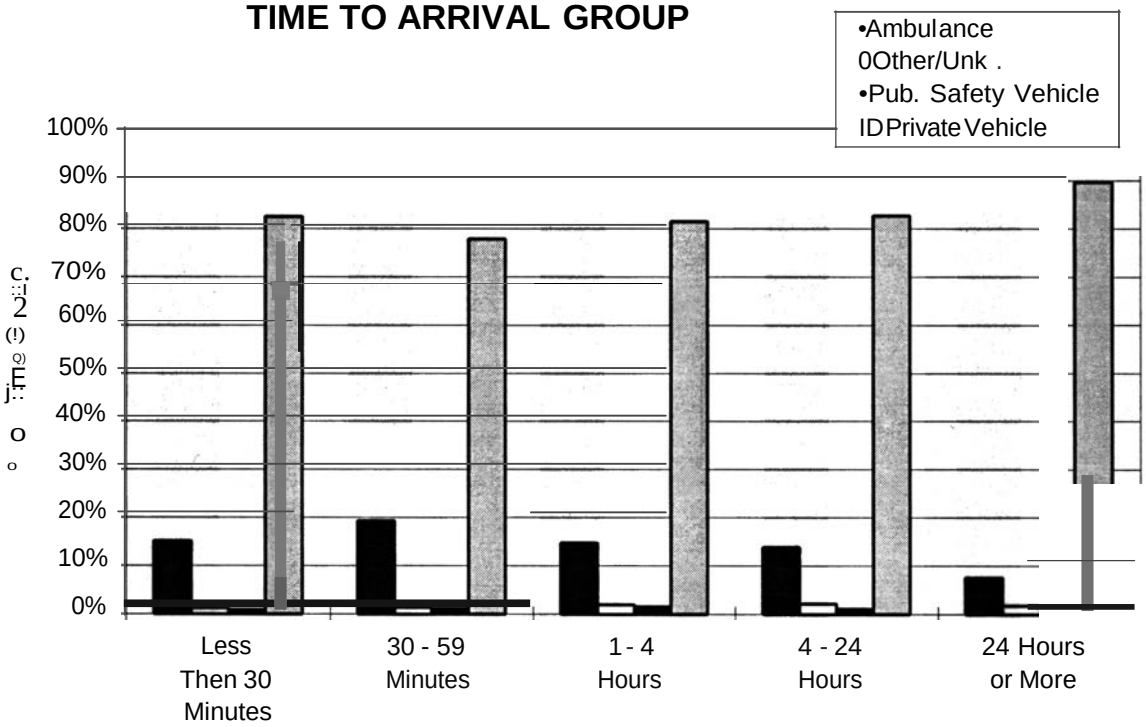
DISPOSITION AS A PERCENT OF AGE GROUP



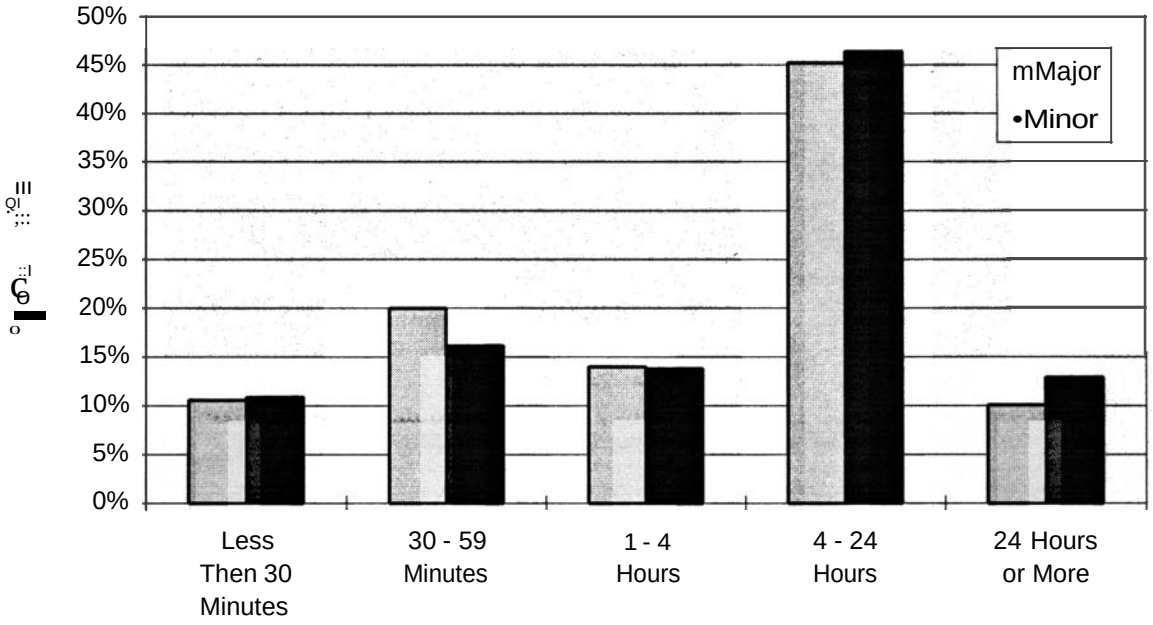
TIME TO ARRIVAL
(Time Patient Arrived in ED - Time Injury Occurred)



MODE OF ARRIVAL FOR EACH TIME TO ARRIVAL GROUP



DISTRIBUTION OF TIME TO ARRIVAL FOR MAJOR AND MINOR INJURIES



Major Injury : Disposition = Admit or Transfer or DOA/Died in ER
or GCS < 13 or SYS BP < 90 or Respitory Rate < 10 or > 29

Minor Injury : All Others

FARM INJURIES FOR SIX NORTHWEST IOWA COUNTIES
JULY 1, 1993 - DECEMBER 31, 1993
COMPARISON OF RISS AND SPRAINS REGISTRIES

	SPRAINS	RISS
Hospitalized	6	13
Not Hospitalized	24	84
Other, Unknown	0	2
Fatal		1
		1 Total
		31
		100

Six of the hospitals using RISS for state-mandated farm injury reporting also used their usual method of reporting farm injuries to the SPRAINS registry simultaneously . For the months of overlap, we compared the number of injuries reported by the two methods.

APPENDIX B

IOWA
1994 HOSPITAL TRAUMA FACILITIES ASSESSMENT SURVEY

Total Surveys Sent: 120
Total Surveys Received: 106

EMERGENCY ROOM VISITS

How many total ER patient visits per year do you have?	913,015
How many of your total ER patient visits are trauma related?	298,400

SECTION 1: PHYSICIAN STAFFING

SPECIALTIES

Indicate the number of the following specialist on staff who care for trauma patients:

General Surgeons	284
Orthopedic Surgeons	237
Neurosurgeons	46
Anesthesiologists	251
Nurse Anesthetists	202

How many are Advanced Trauma Life Support (ATLS) providers?

General Surgeons	94 (33%)
Orthopedic Surgeons	3 (1%)
Neurosurgeons	8 (17%)
Anesthesiologists	6 (2%)
Nurse Anesthetists	4 (2%)

For the following specialists, is Advanced Trauma Life Support (ATLS) required to take trauma call?

	YES	NO
General Surgeons	12 (11%)	94 (89%)
Orthopedic Surgeons	1 (1%)	105 (99%)
Neurosurgeons	0 (0%)	106 (100%)
Anesthesiologists	0 (0%)	106 (100%)
Nurse Anesthetists	6 (6%)	100 (94%)

How often are the following specialties available?

	(1)	(2)	(3)	(4)	(Blank)	YES	NO	Blank
General Surgeons	36(34%)	1(1%)	2(2%)	51(48%)	16(15%)	41(39%)	34(32%)	31(29%)
Orthopedic Surgeons	15(14%)	1(1%)	1(1%)	28(26%)	61(58%)	17(16%)	24(23%)	65(61%)
Neurosurgeons	6(6%)	0(0%)	1(1%)	10(9%)	89(84%)	13(12%)	7(7%)	86(81%)
Anesthesiologist	11(10%)	0(0%)	0(0%)	18(17%)	77(73%)	17(16%)	8(8%)	81(76%)
Nurse Anesthetists	31(29%)	0(0%)	1(0%)	43(41%)	31(29%)	39(37%)	24(23%)	43(40%)

(1) = 24 hrs. per day 7 days a week
(2) = 24 hrs. per day 5 days a week
(3) = 24 hrs. per day weekends only
(4) = On Call
Y = Yes
N = No

For specialties not available is consultation provided by another aci/ity?

	Yes	No	Times per year
General Surgeons	23 (22%)	83 (78%)	49
Orthopedic Surgeons	57 (54%)	49 (46%)	481
Neurosurgeons	64 (60%)	42 (40%)	287
Anesthesiologist	22 (21%)	84 (79%)	10
Nurse Anesthetists	17 (16%)	89 (84%)	12

EMERGENCY DEPARTMENT PHYSICIANS

	YES	NO
Do you have a physician staffing the Emergency Department (ED) 24 hours per day 7 days per week?	62 (58%)	44 (42%)

What type of Emergency Physician coverage do you have?

	(1)	(2)	(3)	(4)	(Blank)
Hospital staff Physician	21 (20%)	8 (8%)	1 (1%)	35 (33%)	41 (48%)
ED physicians group	25 (24%)	1 (1%)	21 (20%)	1 (1%)	58 (54%)
Physicians Assistants	2 (2%)	0 (0%)	1 (1%)	12 (11%)	91 (86%)
Resident Physicians	2 (2%)	0 (0%)	5 (5%)	4 (4%)	95 (89%)

(1) = 24 hrs. per day 7 days a week
(3) = 14 hrs. per day weekends only
(1) = 14 hrs per day 5 days a week
(4) = On Call

	YES	NO
I ATLS (Advanced Trauma Life Support) required for to staff ED?	14 (13%)	92 (87%)

If ATLS is not required, how many are ATLS certified.	119

	Per day	Per wk.	Per mon.
If Physicians staffing the ED consult with specialists in another facility, indicate how often this done.	71	188	238

Do you have a designated:

	Yes	No
ED Medical Director	97 (92%)	9 (8%)
Trauma Team	22 (21%)	84 (79%)
Trauma Service	11 (10 %)	95 (90%)
Trauma Service Medical Director	15 (14%)	91 (86%)
Trauma Service Coordinator	14 (13%)	92 (87%)

SECTION 2: FACILITIES

Emergency Department

Nursing	YES	NO
Do you always have, as a minimum, nurses physically present in the Emergency Department 24 hours per day 7 days per week?	56 (53%)	50 (47%)
Ifthe ED is not the only responsibility of the Nurses, what percentage of their time is devoted to ED activities?	(28 %)	NA
Have the Nurses staffing the ED had any special training in trauma care?	57 (54%)	49 (46%)
Circle the type of special training the ED Nurses have completed.		
a)TNCC (Trauma Nurse Core Course)	55 (52%)	51 (48%)
b)TNS (Trauma Nurse Specialist)	3 (3%)	103 (97%)
c)ATM (Advanced Trauma Management)	21 (20%)	85 (80%)

Equipment	YES	NO
Airway control and ventilation equipment, including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitator, pocket masks, and oxygen.	102 (96%)	4 (4%)
Pulse oximetry.	102 (96%)	4 (4%)
End-Tidal C02 determination.	51 (48%)	55 (52%)
Suction devices.	102 (96%)	4 (4%)
Electrocardiograph-oscilloscope-defibrillator	102 (96%)	4 (4%)
Central venous pressure monitoring.	56 (53%)	50 (47%)
Standard IV fluids and administration devices, including large bore catheters.	102 (96%)	4 (4%)
Sterile surgical sets for: Airway control cricothyrotomy, Thoracotomy, Vascular access, Chest decompression	95 (90%)	11 (10%)
Gastric decompression.	97 (92%)	9 (8%)
Drugs necessary for emergency care	102 (96%)	4 (4%)
X-ray availability, 24 hours a day.	100 (94%)	6 (6%)
Two-way communication with vehicles of emergency transport system.	97 (92%)	9 (8%)
Skeletal traction devices, including capability for cervical traction.	63 (59%)	43 (41%)
Arterial catheters	64 (60%)	42 (40%)
Thermal control equipment for patients and for blood and fluids.	71 (67%)	35 (33%)

Operating Room

Staff	YES	NO
Do you have a designated "for trauma" operating room staffed in-house and immediately available 24 hours perday 7 days per week?	11 (10%)	95 (90%)

	In-House	On-Call	Both	Blank
How do you staff operating room (OR) technicians?	14 (13%)	63 (59%)	9 (8 %)	20 (20%)
How do you staff operating room (OR) nurses?	16 (16%)	73 (69%)	11 (10 %)	6 (5 %)

Equipment	YES	NO
Cardiopulmonary bypass capability	13 (12%)	93 (88%)
Operating microscope	68 (64%)	38 (36%)
Thermal control equipment	82 (77%)	24 (23%)
X-ray capability including c-arm image intensifier available 24 hours.	57 (54%)	49 (46%)
Endoscopes	99 (93%)	7 (7%)
Craniotomy instruments	17 (16%)	89 (84%)
Equipment appropriate for fixation of long-bone and pelvic fractures.	62 (58%)	44 (42%)

Postanestheia Recovery

	YES	NO
Do you have a separate Postanestheia Recovery Room (PAR) available.	94 (87%)	12 (23%)

Staffing	On-call	In-House	
IICheck the following that applies to your PAR staffing?	66 (62%)	35 (38%)	11

Equipment	YES	NO
Equipment for continuous monitoring of temperature, hemodynamics, and gas exchange.	86 (81%)	20 (19%)
Equipment for continuous monitoring of intracranial pressure.	13 (12%)	93 (88%)
Pulse oximetry	100 (94%)	6 (6%)
End-tidal C02 determination	60 (57%)	46 (43%)
Thermal control	80 (75%)	26 (25%)

Intensive Care Unit (ICU)

	YES	NO	
Do you have an Intensive Care Unit (ICU)?	*19* (75%)	21(25%)	11

Staffing	On-call	In-House	Other	
Check the following that applies to your ICU staffing?	1 100%)	76(72%)	13(18%)	11

Required Training	YES
ACLS (Advacned Cardiac Life Support)	86 (81%)
CCRN (Critical Care Registered Nurse)	*5* (5%)
TNCC (Trauma Nurse Core Course)	0(0%)
TNS (Trauma Nurse Specialist)	0(0%)
ATM (Advanced Trauma Management)	2 (2%)
Other / Blank	13(12%)

Equipment	YES	NO
Equipped with EKG monitors	90 (85%)	16 (15%)
Resuscitation equipment in ICU	90 (85%)	16 (15%)
Intracranial pressure monitors	17 (16%)	89 (84%)
Designated ICU Manager	72 (68%)	34 (32%)
Designated ICU Medical Director	61(58%)	45 (42%)

Hemodialysis

	YES	NO
Do you have Hemodialysis capabilities?	26 (25%)	80 (75%)

Burn Capabilities

	YES	NO
Burn Center	3 (3%)	103 (97%)
Burn Service	8 (8%)	98 (92%)
Designated Burn area	4 (4%)	102 (96%)
Designated Nurse Manager	4 (4%)	102 (96%)
Designated Burn Medical Director	3 (3%)	103 (97%)

Radiology

Availability

	(1)	(2)	(3)	(4)
Radiologists	13 (12%)	3 (3%)	46 (43%)	45 (42%)
Radiology Technicians	58 (55%)	1 (1%)	41 (39%)	6 (5 %)

(1) = 14 hrs. per day 7 days a week
(1) = 14 hrs per day 5 days a week
(3) = 14 hrs. per day weekends only
(4) = On Call

Service Capabilities	In-House	Mobile	Other / Blank
Angiograms	33(31%)	3(3%)	70(66%)
Nuclear scanning	35(33%)	56(53%)	15(14%)
Ultrasonography	77(73%)	27(25%)	2(2%)
Neuroradiology	16(15%)	3(3%)	87(82%)
Computerized Tomography(CT)	48(45%)	50(47%)	8(8%)
Magnetic Resonance Imaging (MRI)	15(14%)	44(42%)	47(44%)
Teleradiology (electronic sending)	31(29%)	0(0%)	75(71%)

Staffing pattern.	In House (24 hrs day / 7 days per wk.)	On Call (After hours)	Other
CT Technicians	7(7%)	10(66%)	29(27%)
MRI Technicians	oco%)	38(36%)	68(64%)

Laborator

	YES
Is your clinica	62(58%)

Staffing patt	On Call (After hours)
Lab Technicia	68(61 0

Blood	YES	NO
Transfusion capabilities	100(94%)	6(6%)

Blood Types	Units
A+	1,264
A-	400
B+	283
B-	116
AB+	111
AB-	63
O +	1,294
O	477

Laboratory services provided

	YES	NO
Standard analysis of blood, urine, and other body fluids.	104(98%)	2(2%)
Blood typing and cross matching.	103(97%)	3(3%)
Coagulation Studies	104(98%)	2(2%)
Comprehensive Blood Bank or access to central blood bank and storage capabilities.	95(90%)	11(10%)
Blood gases and pH determination.	93(88%)	13(12%)
Microbiology	97(92%)	9(8%)
Drug and alcohol screening.	76(72%)	30(18%)

Rehabilitation

	YES	NO
Designated Rehabilitation Unit	25(24%)	81(76%)
Designated Physician director.	27(25%)	79(75%)
Trained personnel staffing the unit.	36(34%)	70(66%)
Head Injury equipment.	18(17%)	88(83%)
Spinal Cord Injury Equipment	19(18%)	87(82%)
Orthopedic equipment.	67(63%)	39(37%)
Acute hospitalization.	75(71%)	31(29%)
Long-term care.	59(56%)	47(44%)
Outpatient capabilities.	81(76%)	25(24%)

SECTION 3: SPECIAL ACTIVITIES

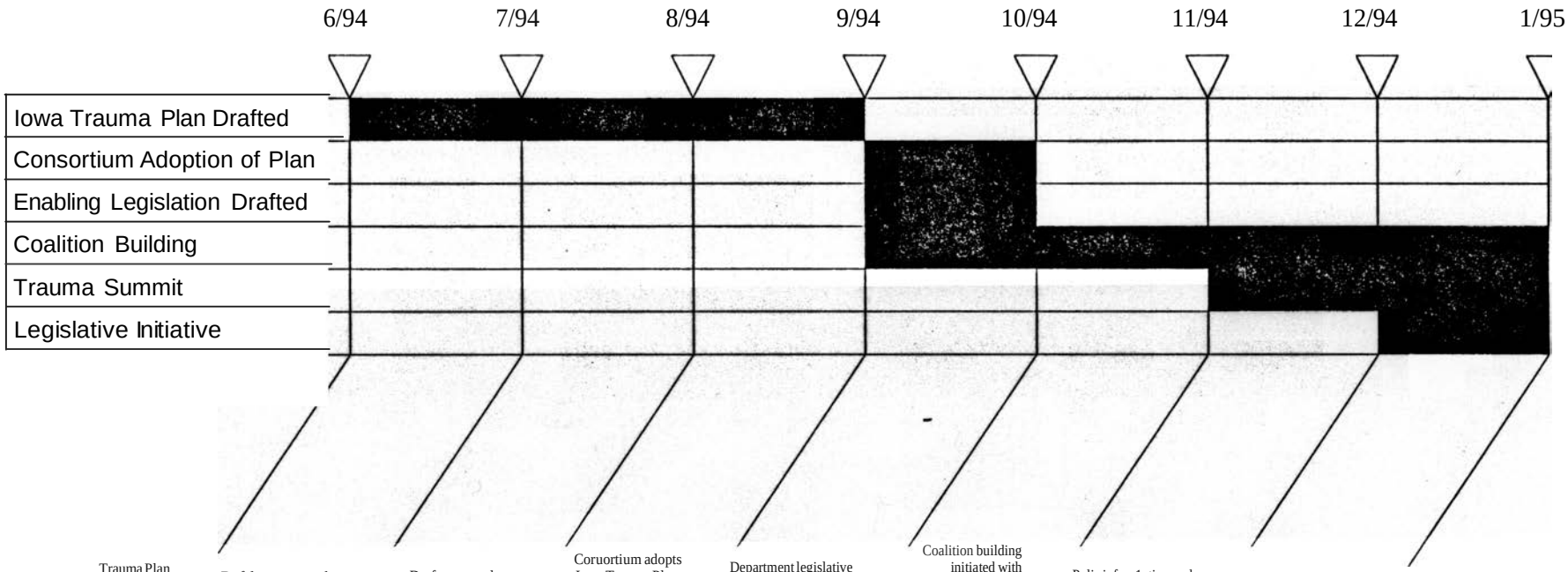
	YES	NO
Do you keep an Emergency Department (ED) Log?	104(98%)	2(2%)
Des the ED log contain the following information?		
(a) Name	103(97%)	3(3%)
(b) Age	98(92%)	8(2%)
(c) Diagnosis	76(72%)	29(8%)
(1) (N-Code)	24(23%)	82(77%)
(d) Description of Injury	72(68%)	34(32%)
(2) (E-Codes)	19(18%)	87(82%)
(e) Patient Occupation	14(13%)	92(87%)
(f) Industry of Patient	18(17%)	88(83%)
(g) Treating Physician	98(92%)	8(8%)
(h) Procedure performed	80(75%)	26(25%)
(I) Severity of Injury	36(34%)	70(66%)
(j) Patient outcomes	75(71%)	31(29%)
Do you retain Ambulance run reports?	85(80%)	21(20%)
Do you have computer capabilities in your ED?	41(39%)	65(61%)
Do the computer capabilities include a mainframe?	33(31%)	73(69%)
Do the computer capabilities include a PC?	35(33%)	71(67%)
Is your ED computer part of the overall hospital system?	33(31%)	73(69%)
If No, is it capable of communicating with the hospital system?	9(8%)	97(92%)
ls it part of a dedicated registration/billing system?	35(33%)	71(67%)
Do you use your ED log for quality assurance?	84(79%)	22(21%)
Does your hospital have a Quality Improvement program?	102(96%)	4(4%)
Do you have dedicated personnel to a Trauma Quality Improvement program?	26(25%)	80(75%)
Does your hospital have a trauma-related bypass policy?	11(10%)	95(90%)
Does your hospital have a Trauma Registry?	18(17%)	88(83%)
Is it computerized	17(99%)	1(1%)
Does your hospital do an Audit for Trauma Deaths?	54(51%)	52(49%)
Does your hospital have Trauma Morbidity and Mortality Review?	40(38%)	66(62%)
Does your hospital have a Multidisciplinary Trauma Conference?	17(16%)	89(84%)
Does your facility review prehospital trauma care?	59(56%)	47(44%)
Do you have published on-call schedules for all surgeons and physicians involved in trauma care?	74(70%)	32(30%)
Do your Trauma Surgeons provide telephone and on-site consultations in their communities?	47(44%)	59(56%)
Does your hospital conduct studies on Injury Control?	23(22%)	83(78%)
Does your hospital have an Injury Prevention Program?	35(33%)	71(67%)
Does your hospital have an Trauma Research Program?	2(2%)	104(98%)
Does your hospital provide Trauma Continuing Education Programs for:		
a. Medical Staff	33(31%)	73(69%)
b. Nurses	66(62%)	40(38%)
c. Allied Health Professionals	39(37%)	67(63%)
d. Physicians other than staff	15(14%)	91(86%)
Does your hospital have a Trauma Transfer Agreement with referral hospitals?	59(56%)	47(44%)
Does your hospital have a Transfer Agreement with a Burn Center to which physicians refer patients	37(35%)	69(65%)
Do you have a Brain Death Policy	40(38%)	66(62%)

Do you have an Organ Procurement Policy	103(97%)	3(3%)
Has your hospital had a American College of Surgeons verification of trauma capabilities visit?	5(5%)	101(95%)
Is your hospital planning on requesting such a visit?	7(7%)	99(93%)

Please provide the following information in regard to your trauma transfer agreements:

	Miles from Facility	Time to provide ground transport	Time to provide helicopter transport
Minimum	1 mile	15 min.	10 min.
Maximum	300 miles	6 hrs.	3 hrs. 20 min.
Average	46 miles	48 min.	25 min.

Trauma Systems Development Legislative Initiative



Trauma Plan Subcommittee or the Consortium continues work on the model traurn1 plan for Iowa.

Dnft language or the Iowa Tramna Plan collated rrom working groups.

Draft tmuna plan wtdcr final review by Trauma Plan Subcommittee .

Coruortium adopts Iowa Trauma Plan. Representatives return to member orgmintions for endoBC111ent.

Department legislative liaison develops enabling legislation to initiate the Iowa Trauma Plan.

Coalition building initiated with educationaJ meetings and legislative sln>tegy sessions with member tions and other interest gtoups.

Pulic infom1ation and education campaign culminates in the Trauma Summit.

Legislator orientation and education. The session begins ...

APPENDIX D

IOWA DEPARTMENT OF PUBLIC HEALTH
CURRENT EMS PROVIDERS
(10-10-94)

	F	G	A	D	I	P	REGION TOTAL	T	R
*	63	3	109	49	35	137	396	16	6
NW	455	217	272	746	214	101	2005	45	218
SW	492	127	335	486	122	68	1630	72	59
NC	349	129	258	584	126	66	1512	47	45
SC	599	250	467	594	292	295	2497	59	94
NE	1000	333	501	929	319	309	3391	83	101
SE	541	367	388	856	226	351	2729	120	170
STATE	3499	1426	2330	4244	1334	1327	14160	442	693

F = First Responder
G = First Responder Defibrillation
A = Emergency Medical Technician Ambulance
D = Emergency Medical Technician Defibrillation
I = Emergency Medical Technician Intermediate
P = Paramedic
T = EMS Instructor Endorsement
R = Emergency Rescue Technician Endorsement

NW = North West Region
SW = South West Region
NC = North Central Region
SC = South Central Region
NE = North East Region
SE = South East Region

APPENDIX E

DRAFT
CONSORTIUM DRAFT II
(11/16194)

STATEWIDE TRAUMA CARE SYSTEM

NEW DIVISION

147A.20 Title of division.

This law may be cited as the "Iowa Trauma Care Systems Development Act".

147A.21 Definitions.

As used in this division, unless the context otherwise requires:

1. "Categorization" means a preliminary determination by the department that a hospital or other appropriate emergency care facility is capable of providing trauma care in accordance with criteria established for level I, II, III and IV care capabilities.
2. "Department" means the department of public health.
3. "Director" means the director of the department of public health.
4. "Emergency care facility" means a physicians office, clinic or other health care center which provides emergency medical care in conjunction with other primary care services.
5. "Hospital" means a facility licensed under chapter 135, or a comparable emergency care facility located and licensed in another state.
6. "Iowa Trauma Plan" means the trauma plan developed by the Iowa trauma systems development consortium, as adopted and presented to the director of public health.
7. "Verification" means a formal process by which the department certifies a hospital or other emergency care facility's capacity to provide trauma care services in accordance with criteria established for level I, II, III and IV trauma care facilities.
8. "Trauma" means a single or multisystem life-threatening or limb-threatening injury, or any injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.
9. "Trauma care facility" means a hospital or emergency care facility which provides trauma care and has been verified by the department as having level I, II, III or IV care capabilities and issued a certificate of verification pursuant to 147A.24(4)c.
10. "Trauma care system" means an organized approach to providing personnel, facilities, and equipment for effective and coordinated trauma care. The trauma care system shall: 'Identify facilities with specific capabilities to provide care, triage trauma victims at the scene, and direct trauma victims to an appropriate trauma care facility.

147A.22 Legislative findings and intent -purpose.

The general assembly finds the following:

1. Trauma is a serious health problem in the state of Iowa and is the leading cause of death oflowans aged 1 to 44. The death and disability associated with traumatic injury contributes to the significant medical expenses, lost work and productivity of Iowans.

2. Optimal trauma care is limited in many parts of the state. With health care delivery in transition, access to quality trauma and emergency medical care continues to challenge our rural communities.

3. The goal of a statewide trauma care system is to coordinate the medical needs of the injured person with an integrated system of optimal and cost-effective trauma care. The result of a well-coordinated statewide trauma care system is to reduce the incidences of inadequate trauma care and preventable deaths, minimize human suffering, and decrease the costs associated with preventable mortality and morbidity.

4. The development of the Iowa trauma care system will achieve these goals while meeting the unique needs of the rural residents of the state.

147A.23 Trauma care systems development

1. The department is designated as the lead agency for trauma care systems development.

2. The department, in consultation with the trauma systems advisory council, shall develop, coordinate and monitor a statewide trauma care system. This shall include, but not be limited to, the following:

a. All hospitals and other appropriate emergency care facilities shall be categorized by the department as to their capacity to provide trauma care services. This categorization will be determined by self-reported information provided to the department by the hospital or emergency care facility. This categorization shall not be construed to imply any guarantee on the part of the department as to the level of trauma care available at the hospital or emergency care facility.

b. All categorized hospitals and emergency care facilities shall obtain a certificate of verification from the department at the level preferred by the hospital or emergency care facility. The standards and verification process shall be established by rule and will vary as appropriate by level of trauma care capability. To the extent possible, the standards and verification process shall be coordinated with other accreditation and liGensing standards when applicable.

c. With verification and the issuance of a certificate of verification, a hospital or emergency care facility agrees to maintain a level of commitment and resources sufficient to meet responsibilities and standards as required by the trauma care criteria established by rule under this division. Verifications are valid for a period of three years or as determined by the department and are renewable. As part of the verification and renewal process, the department may conduct periodic on-site reviews of the services and facilities of the hospital or other emergency care facility.

d. The department may establish fees to help defray the costs of this section. All fees generated shall be deposited in the emergency medical services fund as established in 135.25.

e. This section shall not restrict the ability of a hospital or emergency care facility from providing services for which it has been duly authorized.

f. Nothing in this section shall be construed to limit the number and distribution of level I, II, III and IV categorized and verified trauma care facilities in a community or region.

147A.24 Trauma systems advisory council established.

1. The trauma systems advisory council is established The following organizations may recommend a representative to the council:

a. The department of public health.
b. Iowa chapter, American college of surgeons.
c. Iowa chapter, American college of emergency physicians.
d. Iowa emergency nurses association.
e. Iowa hospital association representing rural hospitals.
f. Iowa hospital association representing urban hospitals.
g. Iowa emergency medical services association.
h. Iowa medical society.
i. Iowa osteopathic medical society.
j. Governor's traffic safety bureau.
k. state medical examiner.
l. trauma nurse coordinator representing a trauma registry hospital.
m. American academy of pediatrics.
n. rehabilitation services.
o. state emergency medical services medical director.
p. University oflowa, injury prevention research center.

2. The council shall be appointed by the director from the recommendations of the organizations in subparagraph 1 for terms of two years. Vacancies on the council shall be filled for the remainder of the term of the original appointment. Members whose terms expire may be reappointed.

3. The voting members of the cot.incil shall appoint a chairperson and a vice chairperson and other officers as the council deems necessary. The officers shall serve until their successors are appointed and qualified.

4. The council shall:

a. Advise the department on issues and strategies to achieve optimal trauma care delivery throughout the state.

b. Assist the department in the implementation of the Iowa trauma plan.

c. Develop criteria for the categorization of all hospitals and other emergency care facilities according to their trauma care capabilities. These categories shall be for levels I, II, III and IV based on the most current guidelines published by the American College of Surgeons Committee on Trauma, the American College of Emergency Physicians, and the Department of Health and Human Services Health Resources and Services Administration model trauma care plan. This will include a process for the verification of the trauma care capacity of each facility and the issuance of a certificate of verification.

d. Develop standards for medical direction, trauma care, triage and transfer protocols, and trauma registries.

e. Promote public information and education activities for injury prevention.

f. Review the rules promulgated under this division and make recommendations to the director for changes to further promote optimal trauma care.

147A.25 System evaluation and quality improvement.

1. The department shall create a systems evaluation and quality improvement committee to develop, implement and conduct trauma systems evaluation, quality assessment and quality improvement. Membership will be appointed by the director and shall include:

a. two trauma surgeons.
b. one neurologic surgeon and one orthopedic surgeon.
c. two emergency physicians.
d. two trauma nurse coordinators.
e. two emergency nurses.
f. two prehospital care providers.
g. department of public health trauma coordinator.
h. Iowa foundation of medical care.
1. state emergency medical services medical director.

2. Patient care quality assurance proceedings, records, and reports developed pursuant to this section constitute peer review records under section 147.135, and are not subject to discovery by supeona or admissible as evidence. All information and documents received from a hospital under this division shall be confidential pursuant to section 272C.6, subsection 4.

147A.26 Trauma registry.

1. The department shall maintain a statewide trauma reporting system by which the systems evaluation and quality improvement committee, the trauma systems advisory council and the department may monitor the effectiveness of the trauma care system.

2. The data collected by and furnished to the department pursuant to this section shall not be public records under chapter 22. The compilations prepared for release or dissemination from the data collected shall be public records under chapter 22, which are not subject to section 22.7, subsection 2. The confidentiality of patients is to be protected and the laws of this state in regard to patient confidentiality apply.

3. To the extend possible, activities under this section shall be coordinated with other health data collection methods.

147A.27 Department to adopt rules.

Prior to the implementation of this division, department shall adopt rules in accordance with the Iowa trauma plan which specify:

1. standards for trauma care.
2. triage and transfer protocols.
3. trauma registry.
4. education and training requirements.
5. hospital and emergency care facility categorization criteria.
6. approval, denial, probation and revocation of certificates of verification.

147A.28 Immunity.

Individuals and facilities providing trauma care are not civilly liable for negligence for acting in accordance with the Iowa trauma plan, rules or protocols established under this division.

147A.29 Prohibited Acts.

1. Any hospital or emergency care facility who imparts or conveys, or causes to be imparted or conveyed, that they are a trauma care facility, or who uses any other term to indicate or imply that their hospital or emergency care facility is a trauma care facility without having obtained a certificate of verification under this division is subject to a civil penalty not to exceed one hundred dollars per day for each offense. In addition, the director may apply to the district court, for a writ of injunction to restrain the use of said term

Attachment 64

PIO Courses Offered

IDPH-Sponsored Basic Public Inform		
FY12-13, FY13-14, and F		
Date	**Location**	**Attendees**
July 2012	Shenandoah, Page County	16
June 2013	Washington, Henry County	12
June 2013	Osceola, Clarke County	6
November 2013	Denison, Crawford, County	17
January 2014 *	Ames, Story County	14
January 2014 *	Iowa City, Johnson County	12
March 2014 *	Decorah, Winneshiek, County	21
April 2014 *	Emmetsburgh, Palo Alto County	25
April 2014	Creston, Union County	14
July 2014 *	Oskaloosa, Mahaska County	31
July 2014 *	Council Bluffs, Pottawattamie County	19
July 2014 *	Belmond, Wright County	14
Sept. 2014	Waverly, Bremer County	19
Feb. 2015 *	Waterloo, Black Hawk County	27
March 2015 *	West Burlington, Des Moines County	30
March 2015 *	Sheldon, O'Brien County	30
April 2015 *	Des Moines, Polk County	30
May 2015 *	Council Bluffs, Pottawattamie County	25
	Total	**362**

*** = co-instructed w/ HSEMD**

Green = scheduled, not yet presented

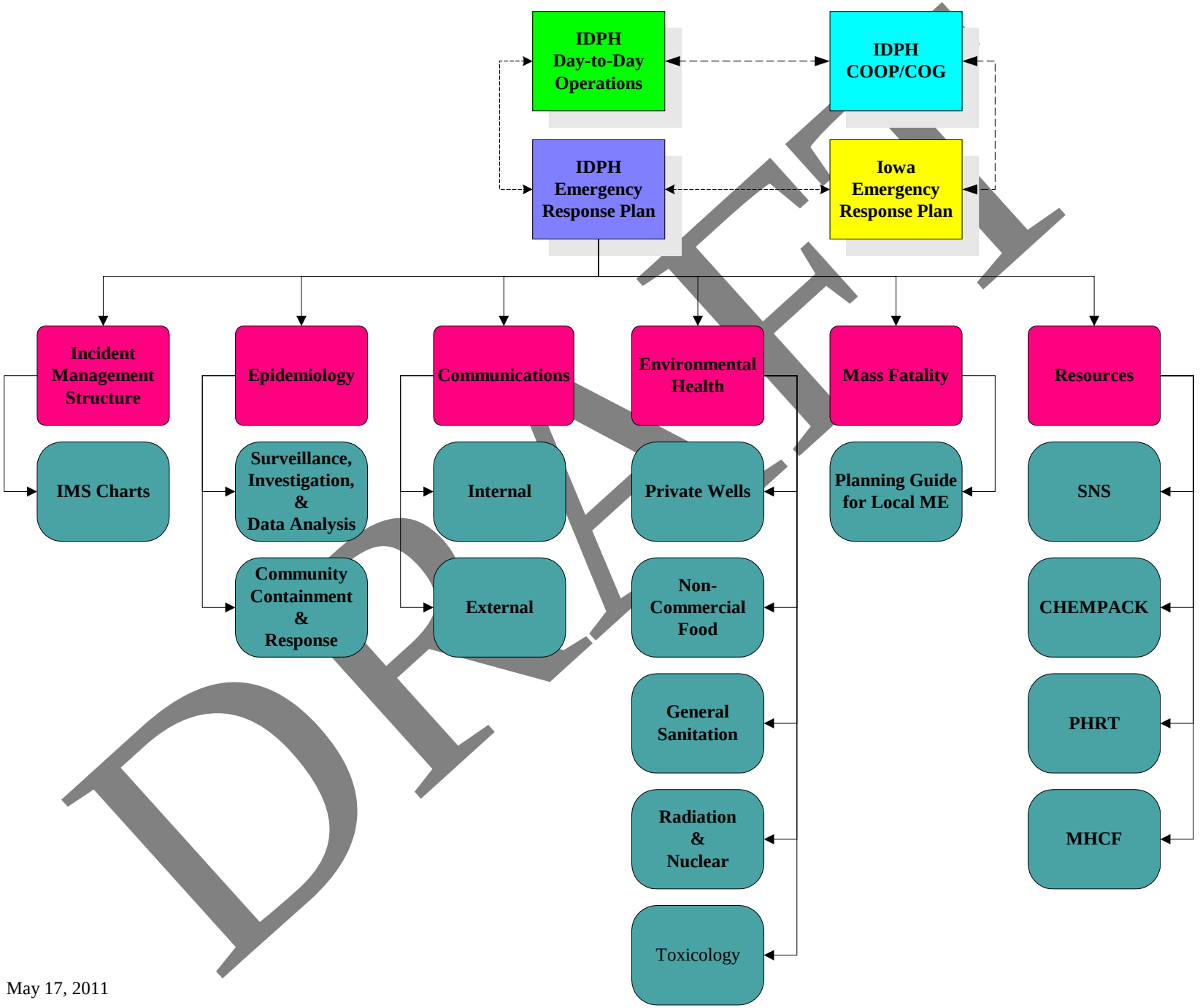
ation Officer Course (G290 and G289)

FY14-15 Course Offerings

Disciplines Represented
PH, Hospitals, Fire, EMS
PH, Hospitals, School Districts, Faith Based, EMA
PH, BOS
PH, Hospitals
PH, Hospitals, EMA, EMS
PH, Hospitals, University PR
PH, Hospitals, Public Library, University PR, County Solid Waste, County IT, EMA, EMS, Fire, Red Cross,
PH, Hospitals, Community College PR, LE,
PH, Hospitals, Sanitarian, City Planner, EMA, BOS, Gas Co., Railroad, Corrections, EMS
PH, Hospitals, Mayor, City Transit, LE, Corrections, EMA
PH, Hospitals, LE, Community College PR, Blood Center
PH, Hospitals, LE, VA Hospital (DM)
PH, Hospitals, city gov't, school district,
PH, Hospitals, LE, EMA, EMS,
PH, hospitals, LE, Fire, EMA, EMS, city gov't, BOS
PH, hospitals, LE, Fire, EMA, EMS, city gov't, BOS
PH, hospitals, LE, Fire, EMA, EMS, city gov't, BOS
PH, hospitals, LE, Fire, EMA, EMS, city gov't, BOS

Attachment 65

IDPH Plan Flow Chart

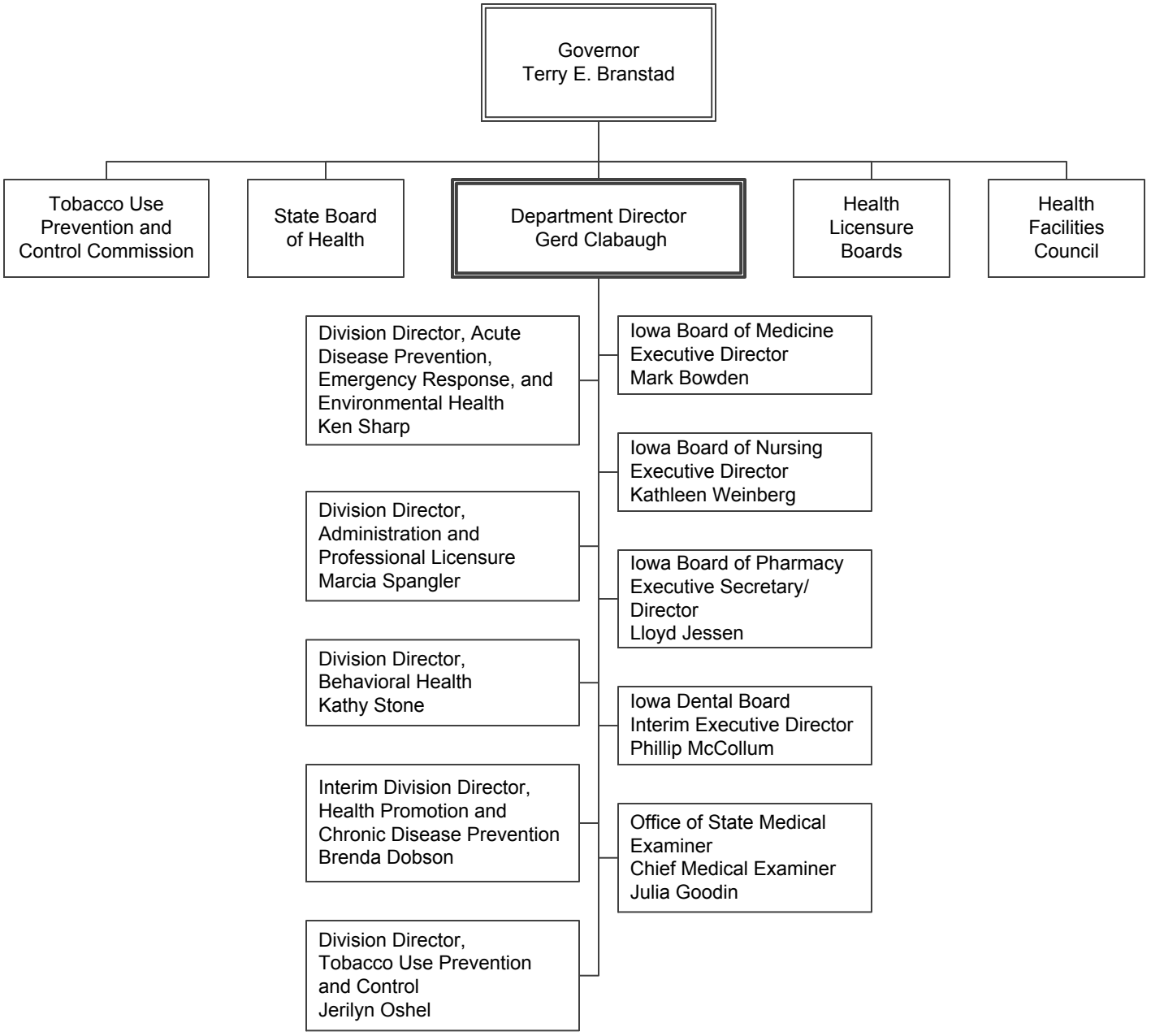


May 17, 2011

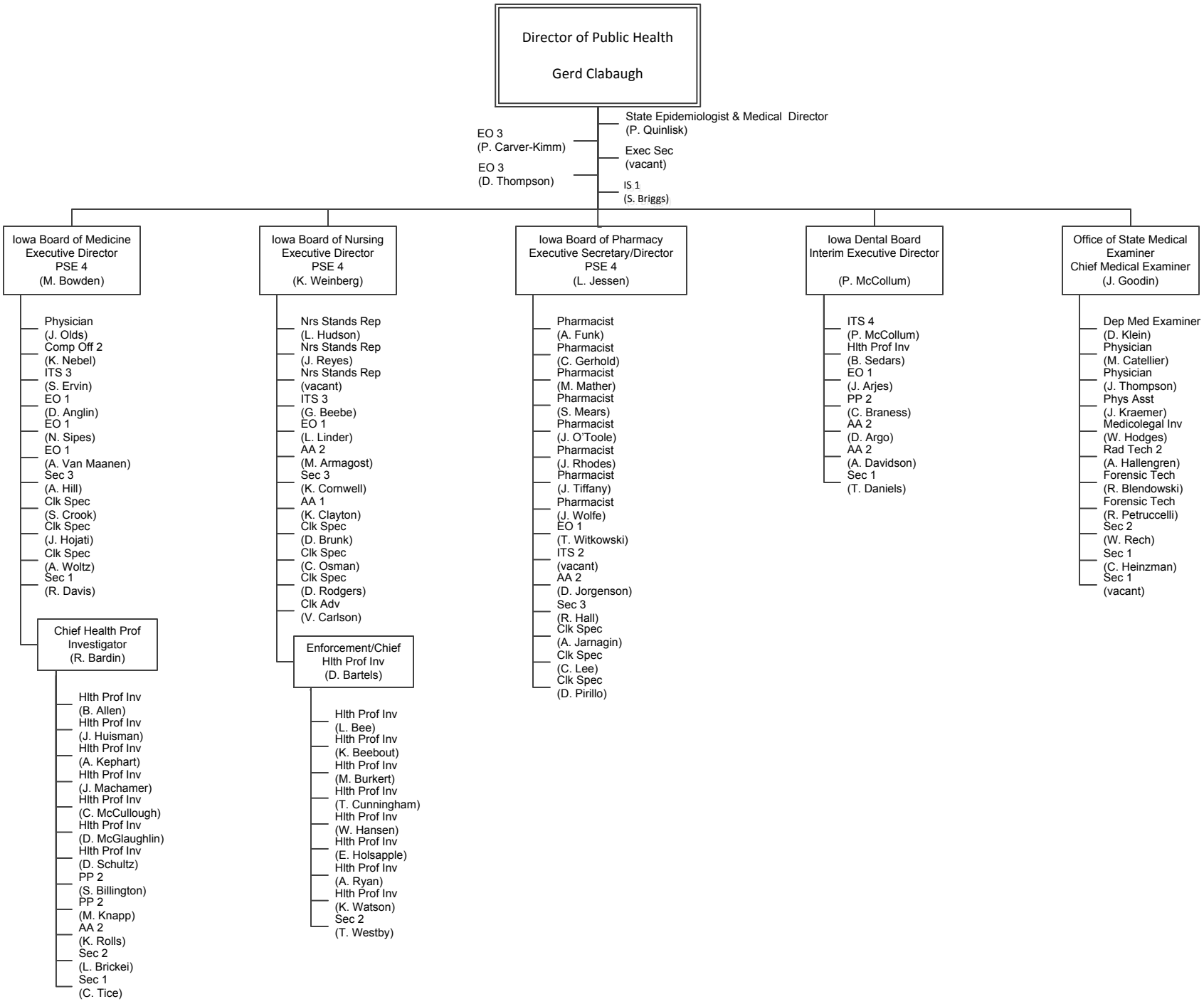
Attachment 66

IDPH Table of Organization

Iowa Department of Public Health

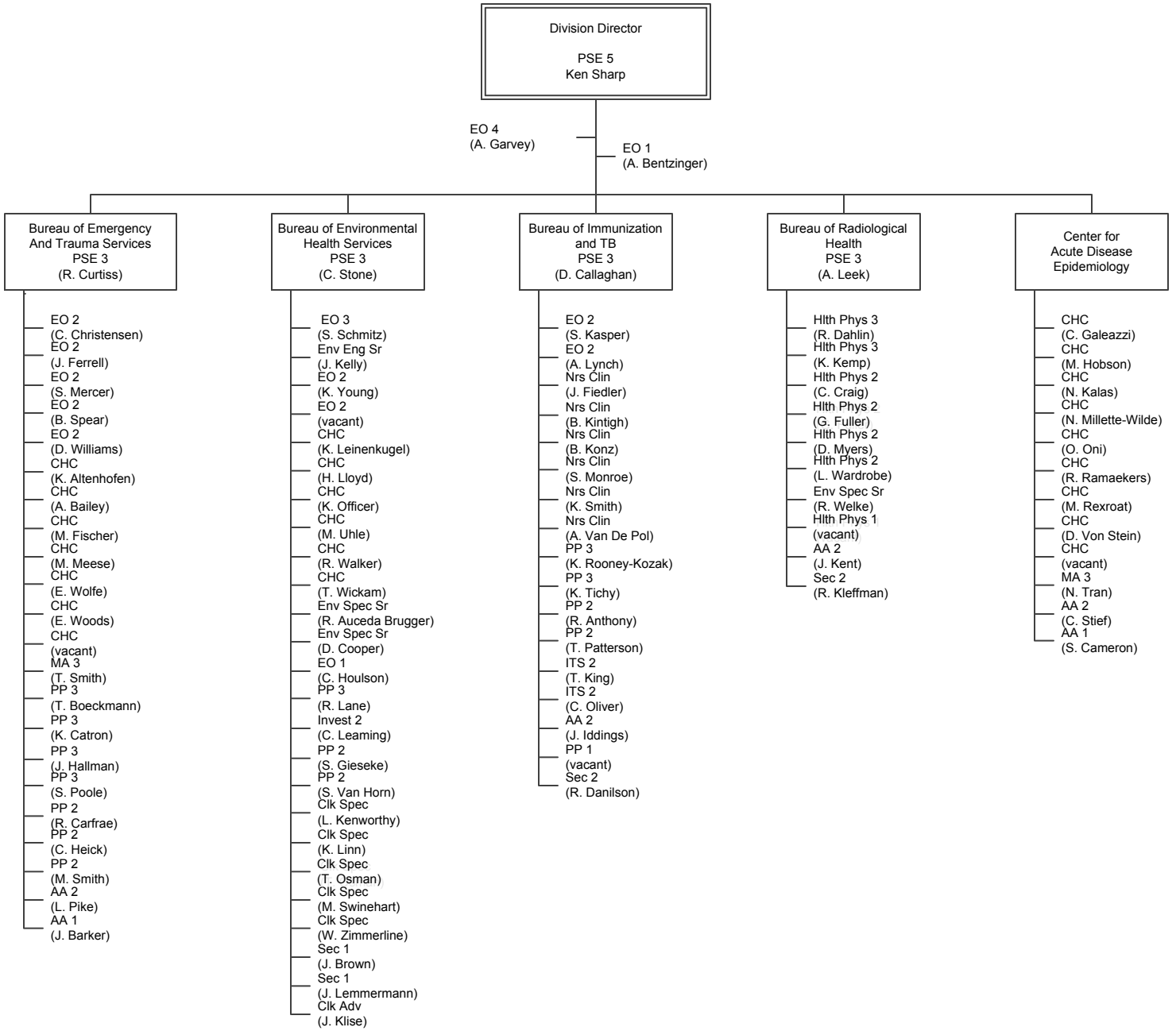


DIRECTOR'S OFFICE

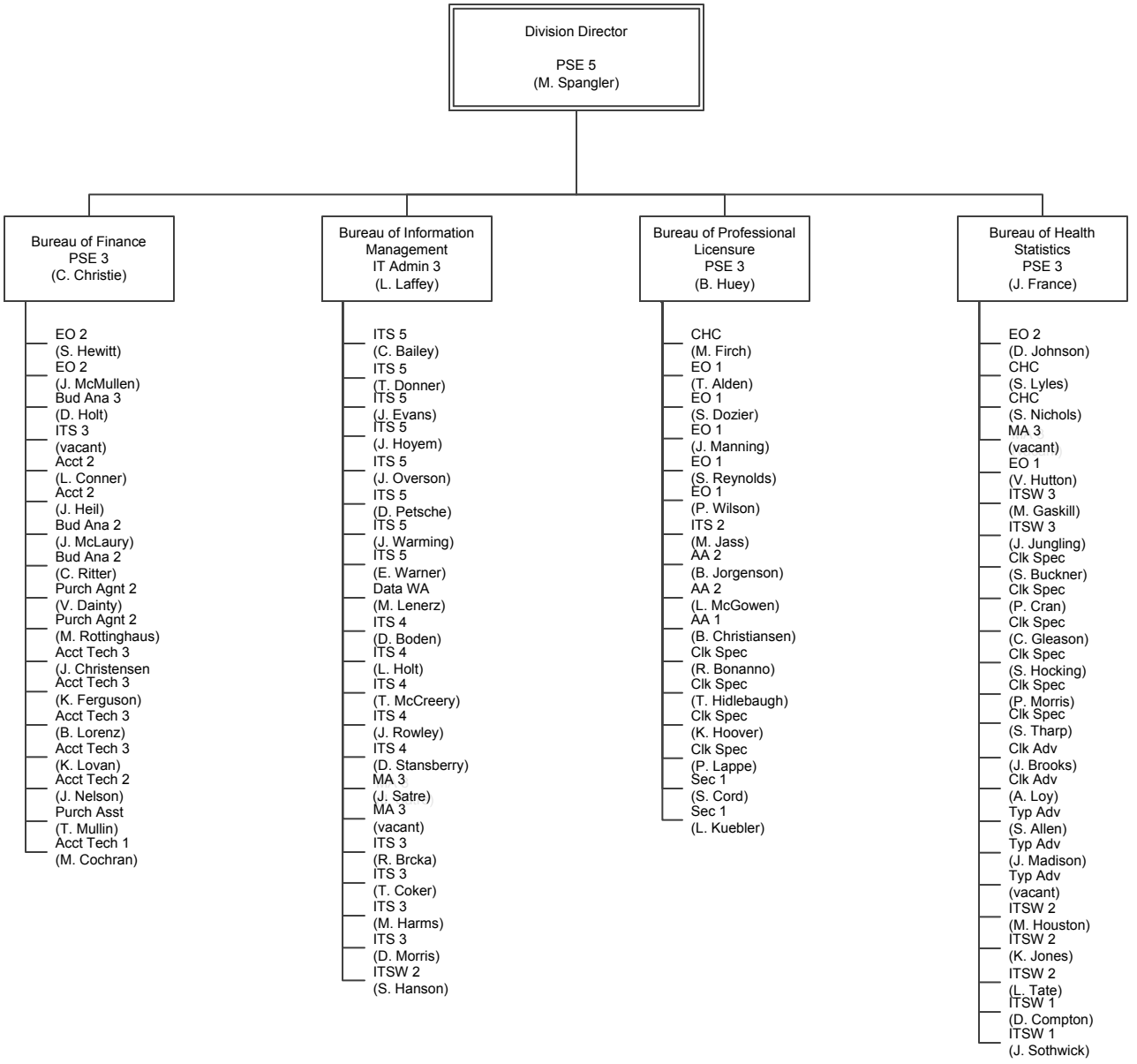


11/20/14

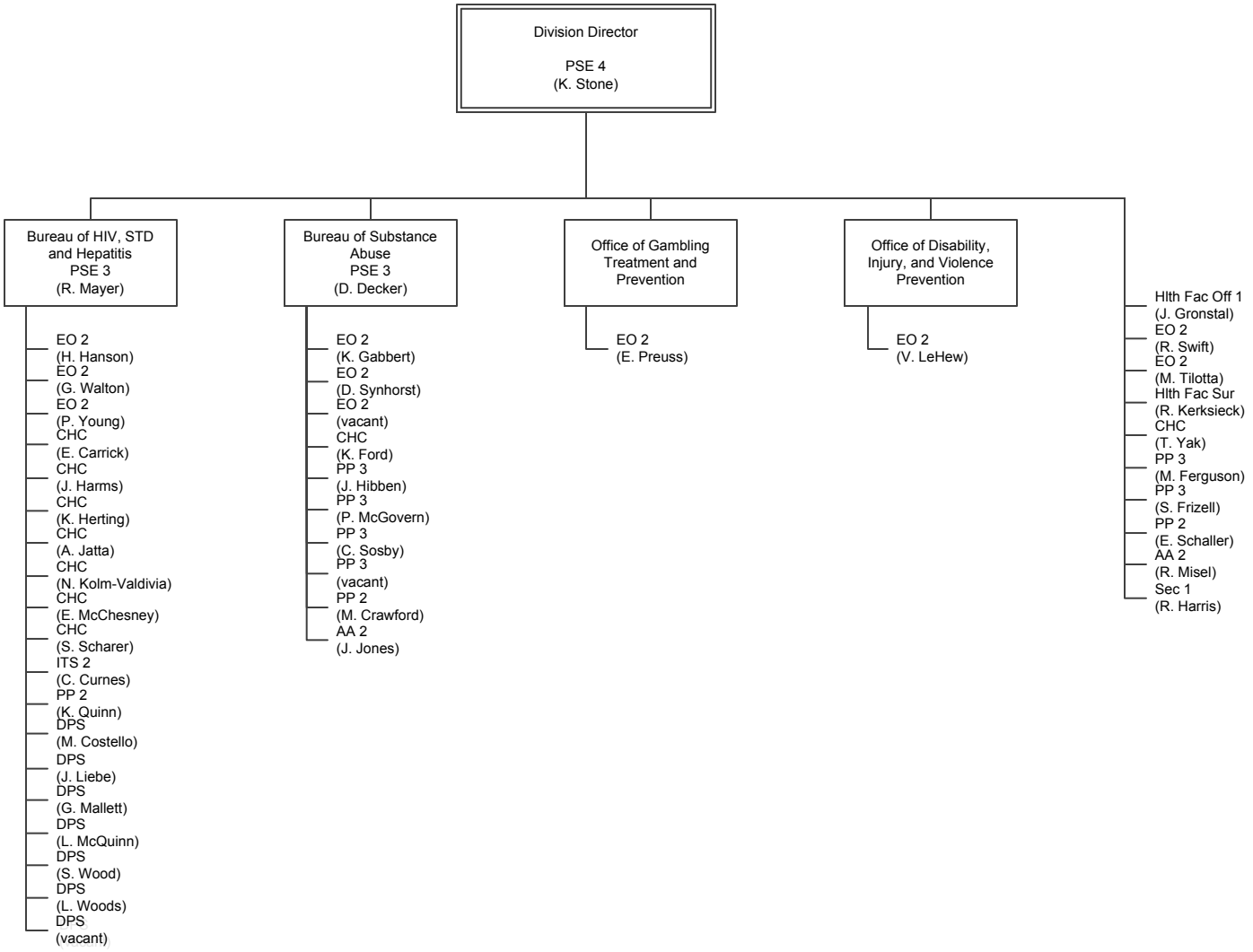
DIVISION OF ACUTE DISEASE PREVENTION, EMERGENCY RESPONSE, AND ENVIRONMENTAL HEALTH



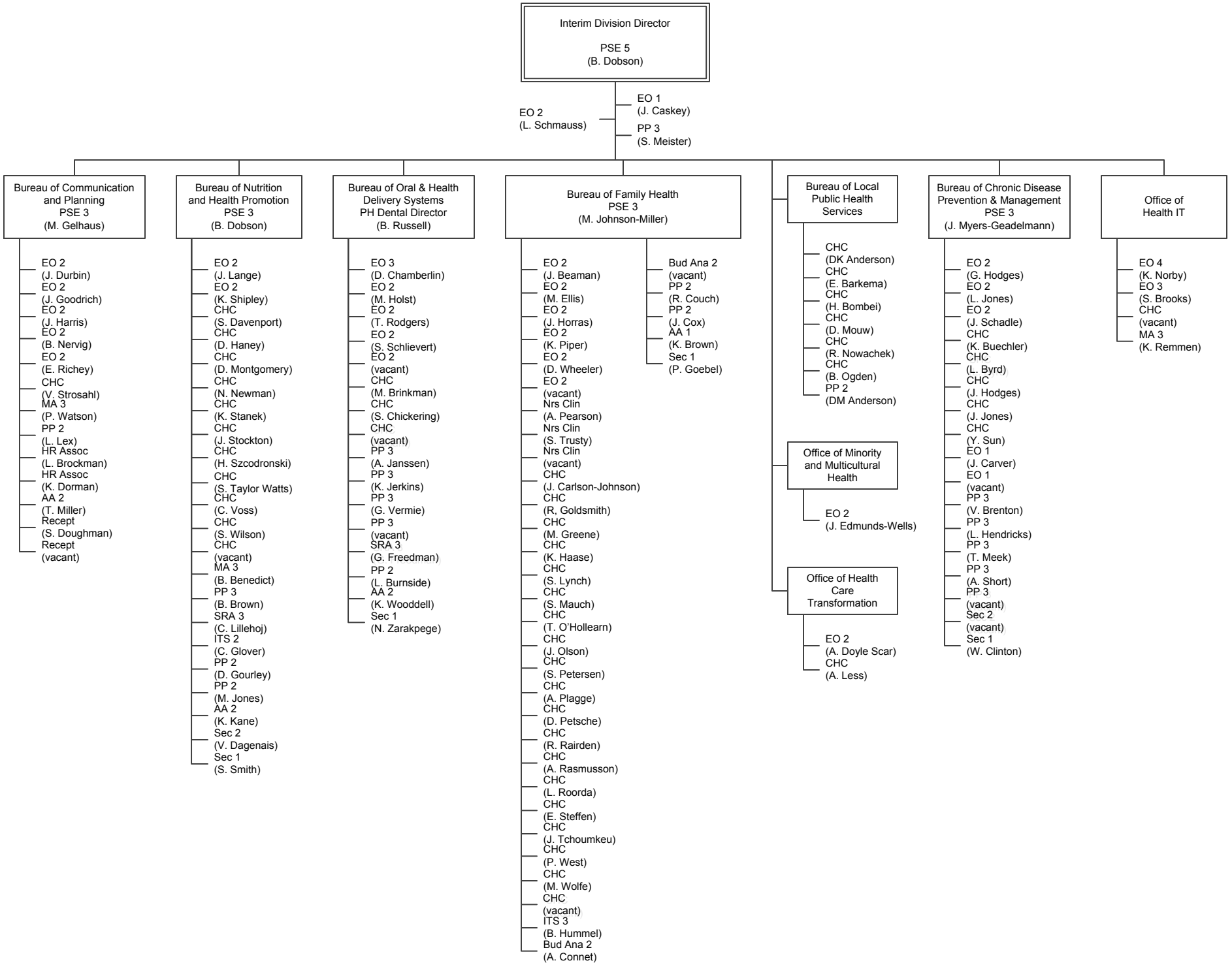
DIVISION OF ADMINISTRATION AND PROFESSIONAL LICENSURE



DIVISION OF BEHAVIORAL HEALTH

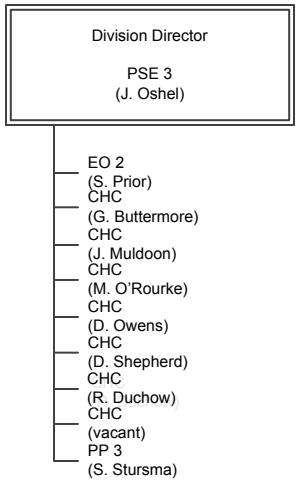


DIVISION OF HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION



11/20/14

DIVISION OF TOBACCO USE PREVENTION AND CONTROL

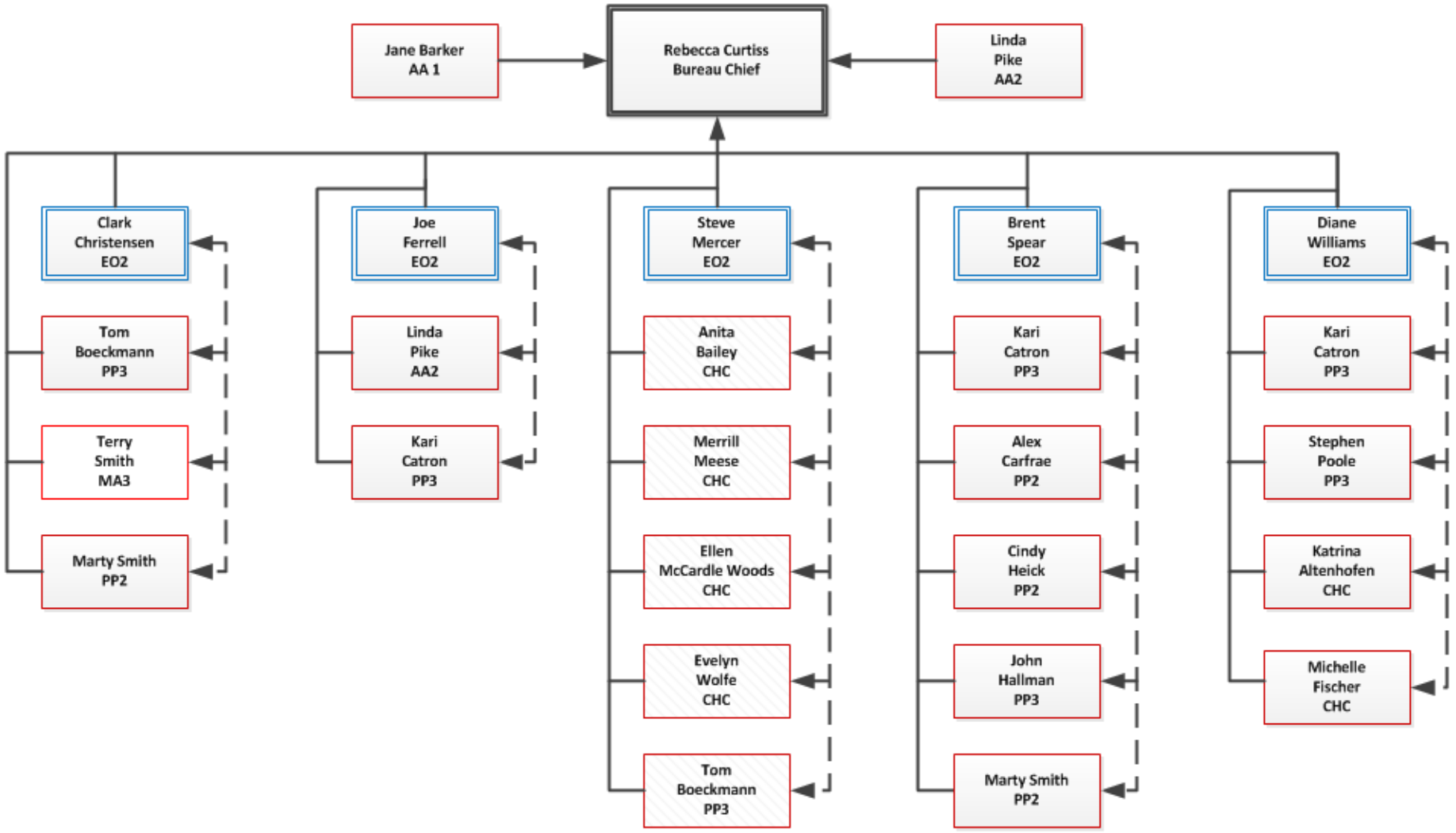


Attachment 67

IDPH Bureau of Emergency and Trauma Services

Table of Organization

Iowa Department of Public Health
Bureau of Emergency and Trauma Services



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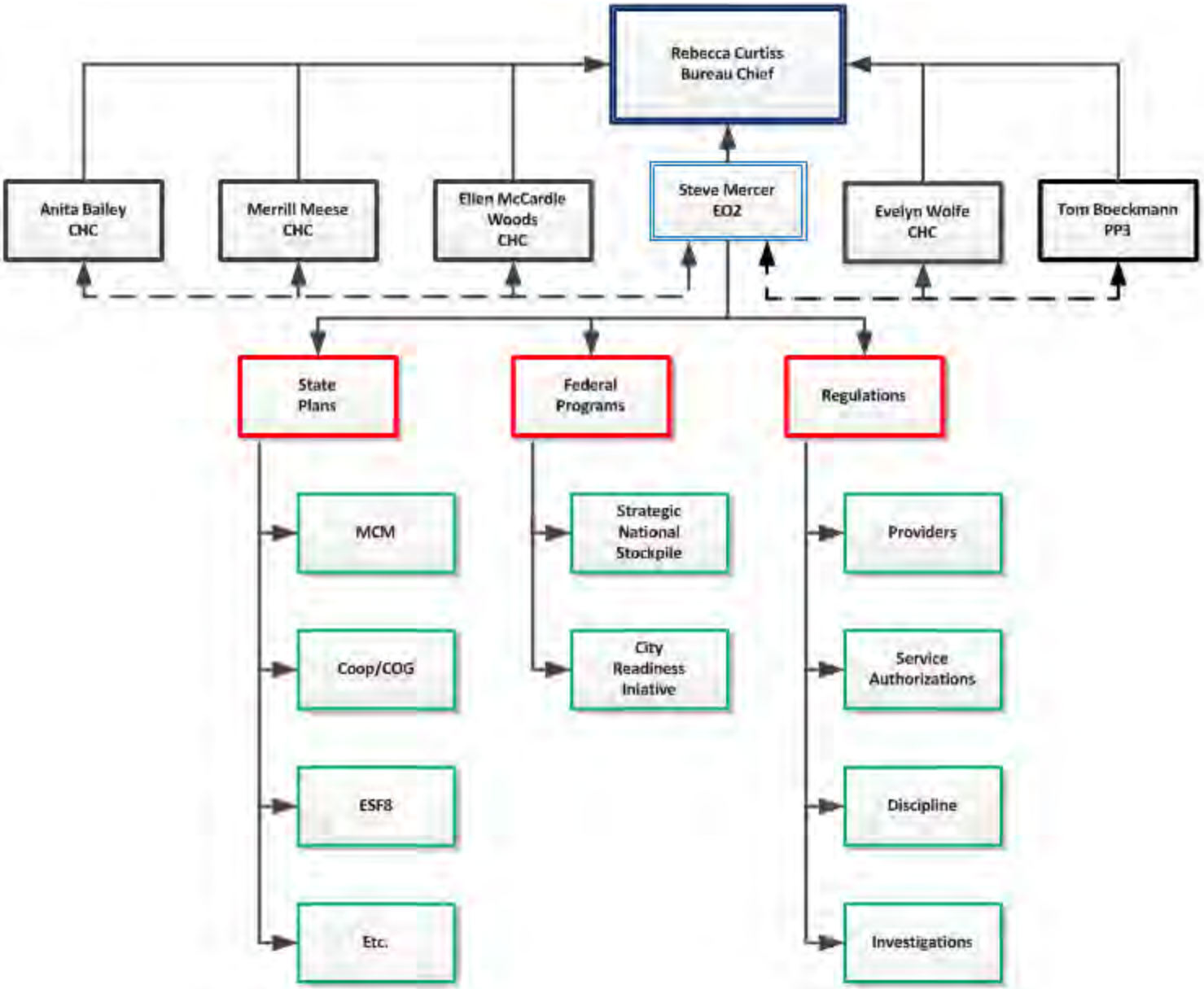
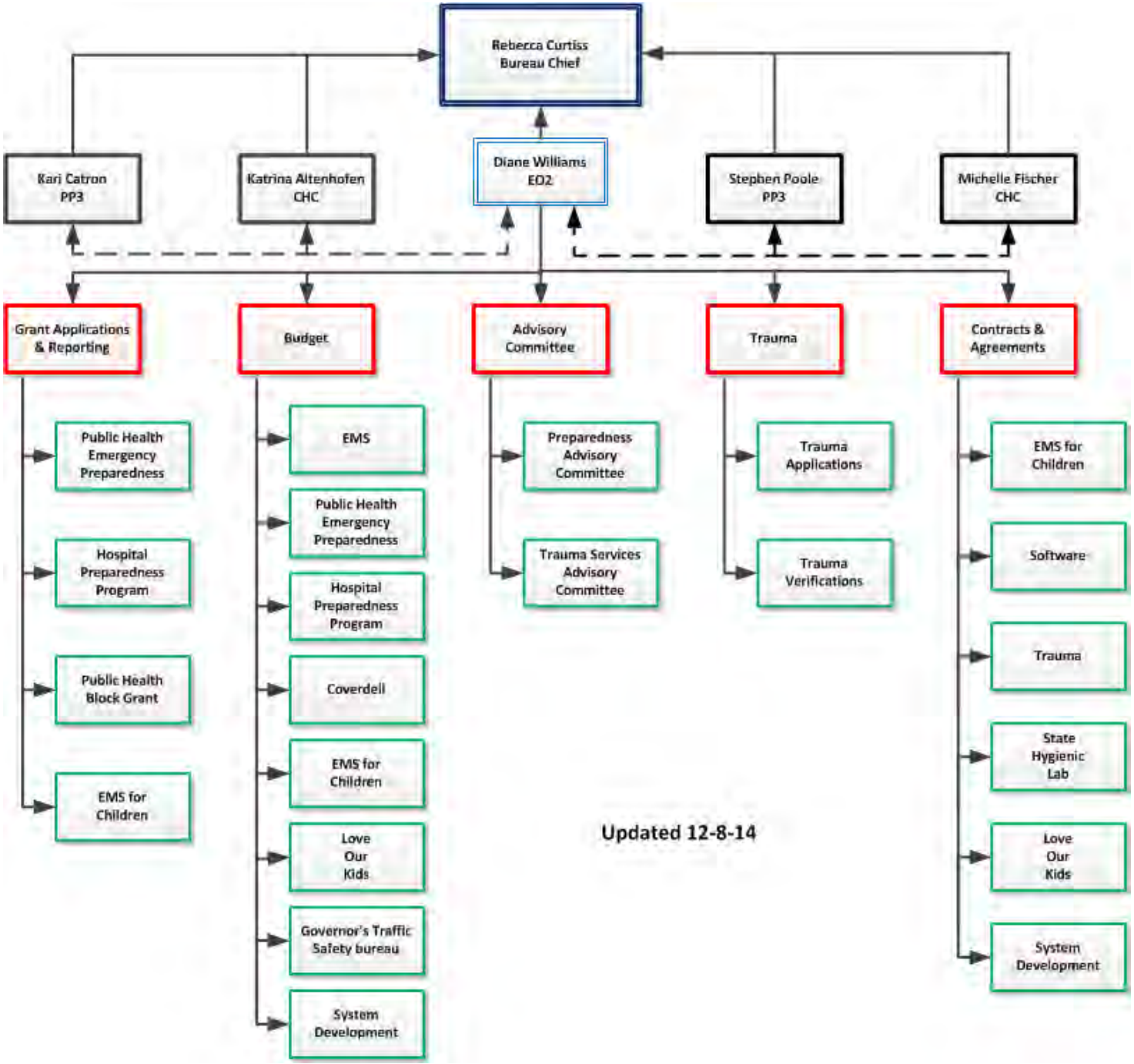
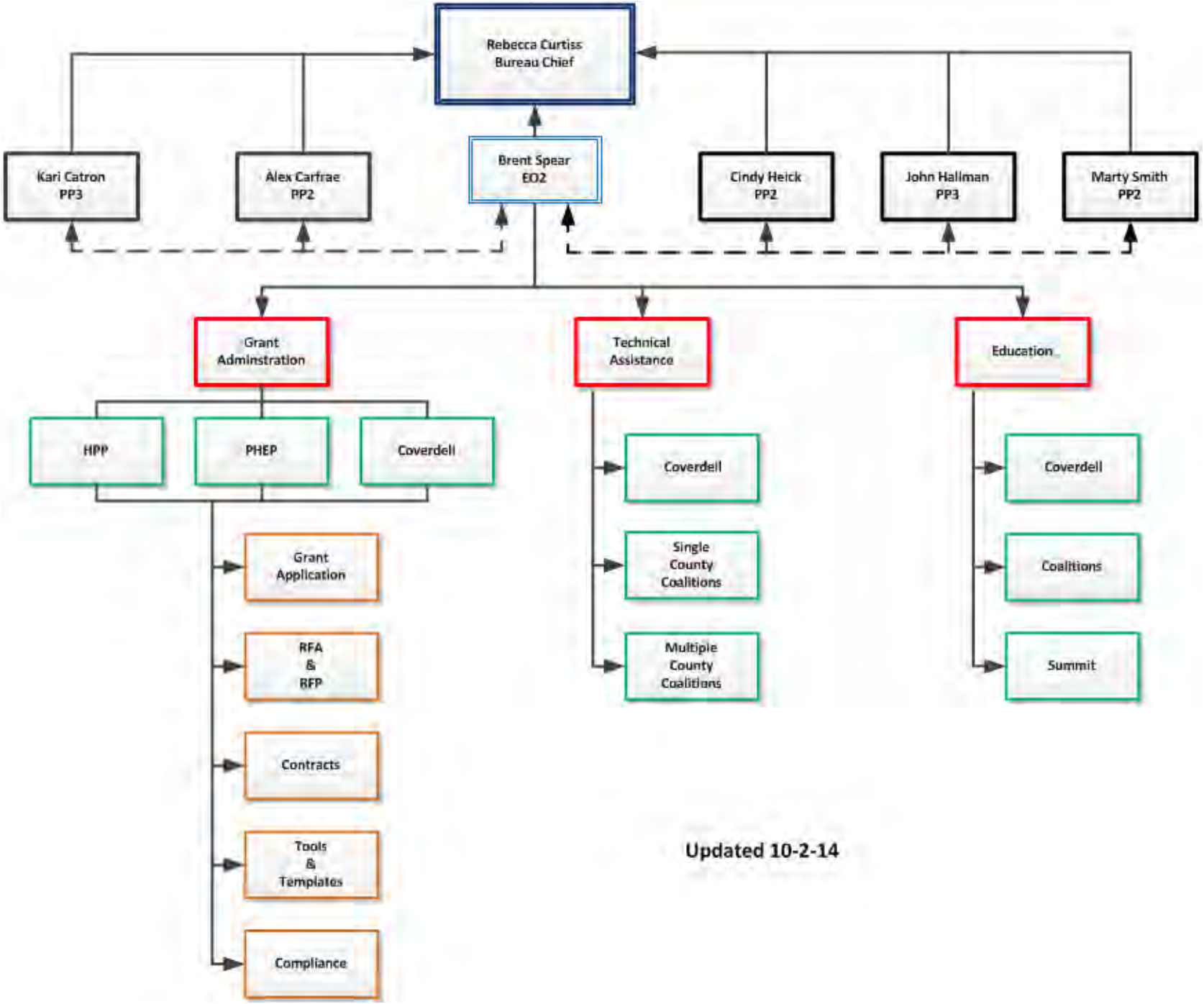
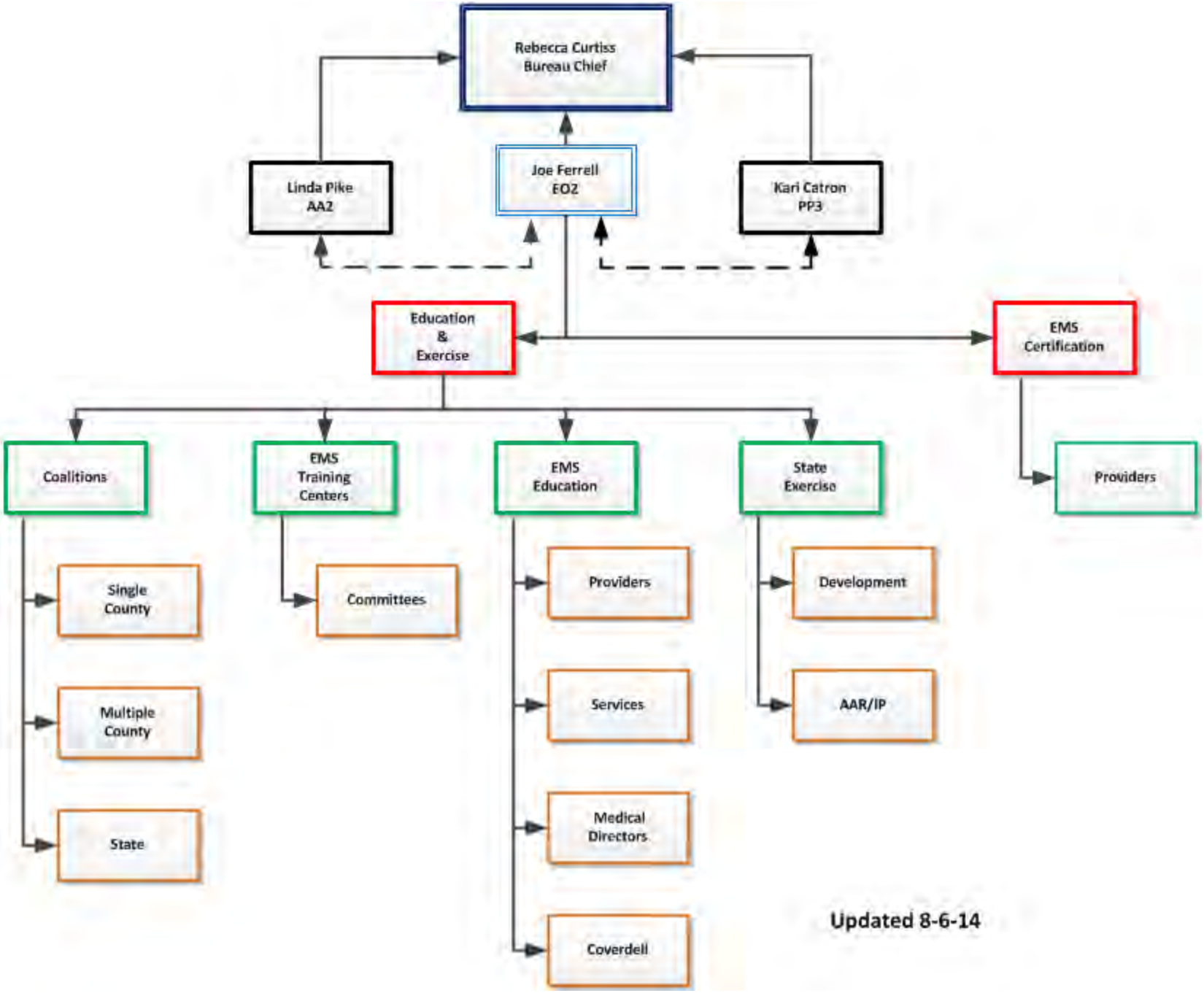
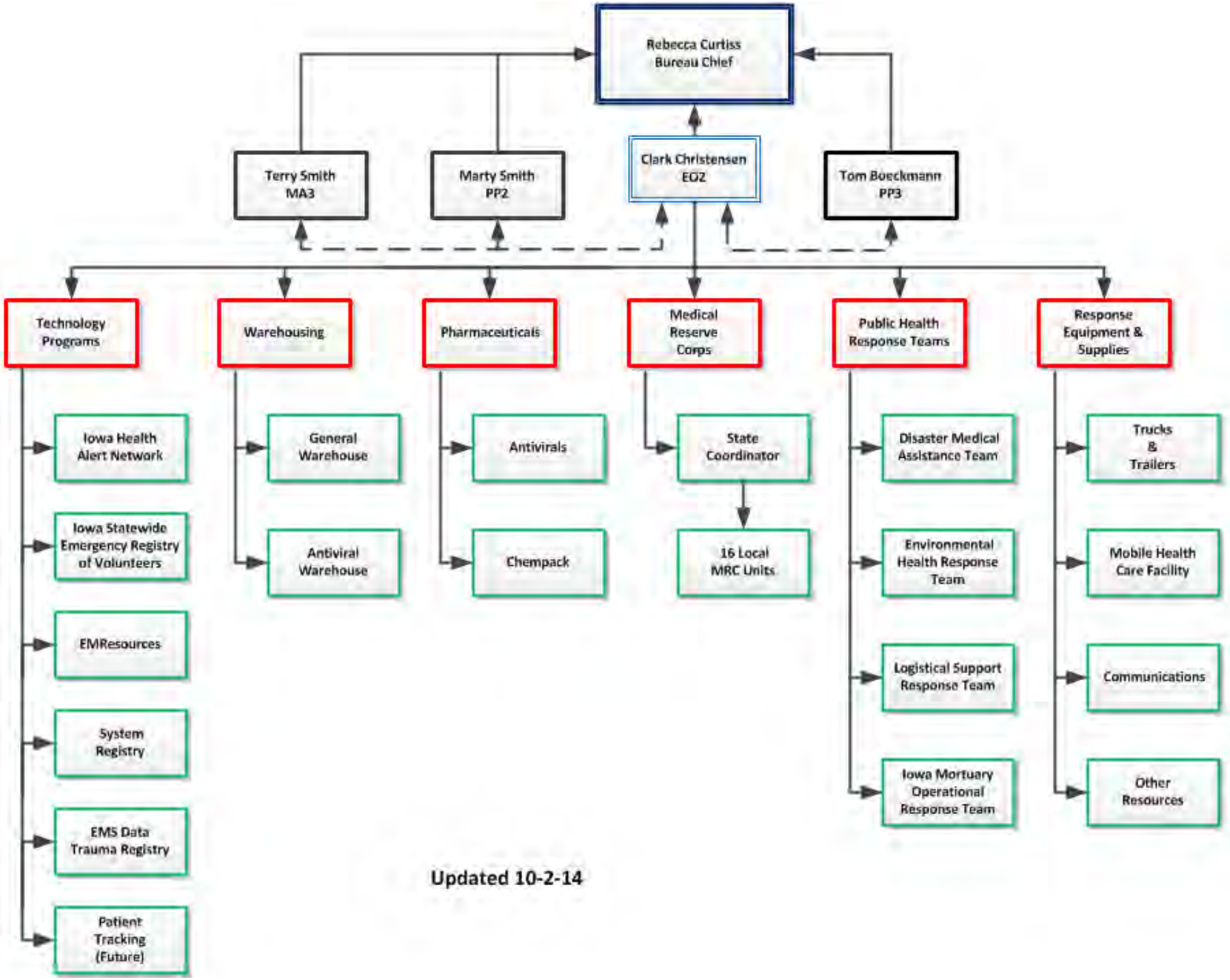


Updated 8-6-14


Rebecca Curtiss
Bureau Chief
Kari Catron
PP3
Katrina Altenhofen
CHC
Diane Williams
EO2
Stephen Poole
PP3
Michelle Fischer
CHC
Grant Applications & Reporting
Budget
Advisory Committee
Trauma
Contracts & Agreements
Public Health Emergency Preparedness
Hospital Preparedness Program
Public Health Block Grant
EMS for Children
EMS
Public Health Emergency Preparedness
Hospital Preparedness Program
Coverdell
EMS for Children
Love Our Kids
Governor's Traffic Safety bureau
System Development
Preparedness Advisory Committee
Trauma Services Advisory Committee
Trauma Applications
Trauma Verifications
EMS for Children
Software
Trauma
State Hygienic Lab
Love Our Kids
System Development
Updated 12-8-14


Rebecca Curtiss
Bureau Chief
Kari Catron
PP3
Alex Carfrae
PP2
Brent Spear
EO2
Cindy Heick
PP2
John Hallman
PP3
Marty Smith
PP2
Grant
Adminstration
Technical
Assistance
Education
HPP
PHEP
Coverdell
Coverdell
Coverdell
Grant
Application
Single
County
Coalitions
Coalitions
RFA
&
RFP
Multiple
County
Coalitions
Summit
Contracts
Tools
&
Templates
Compliance
Updated 10-2-14

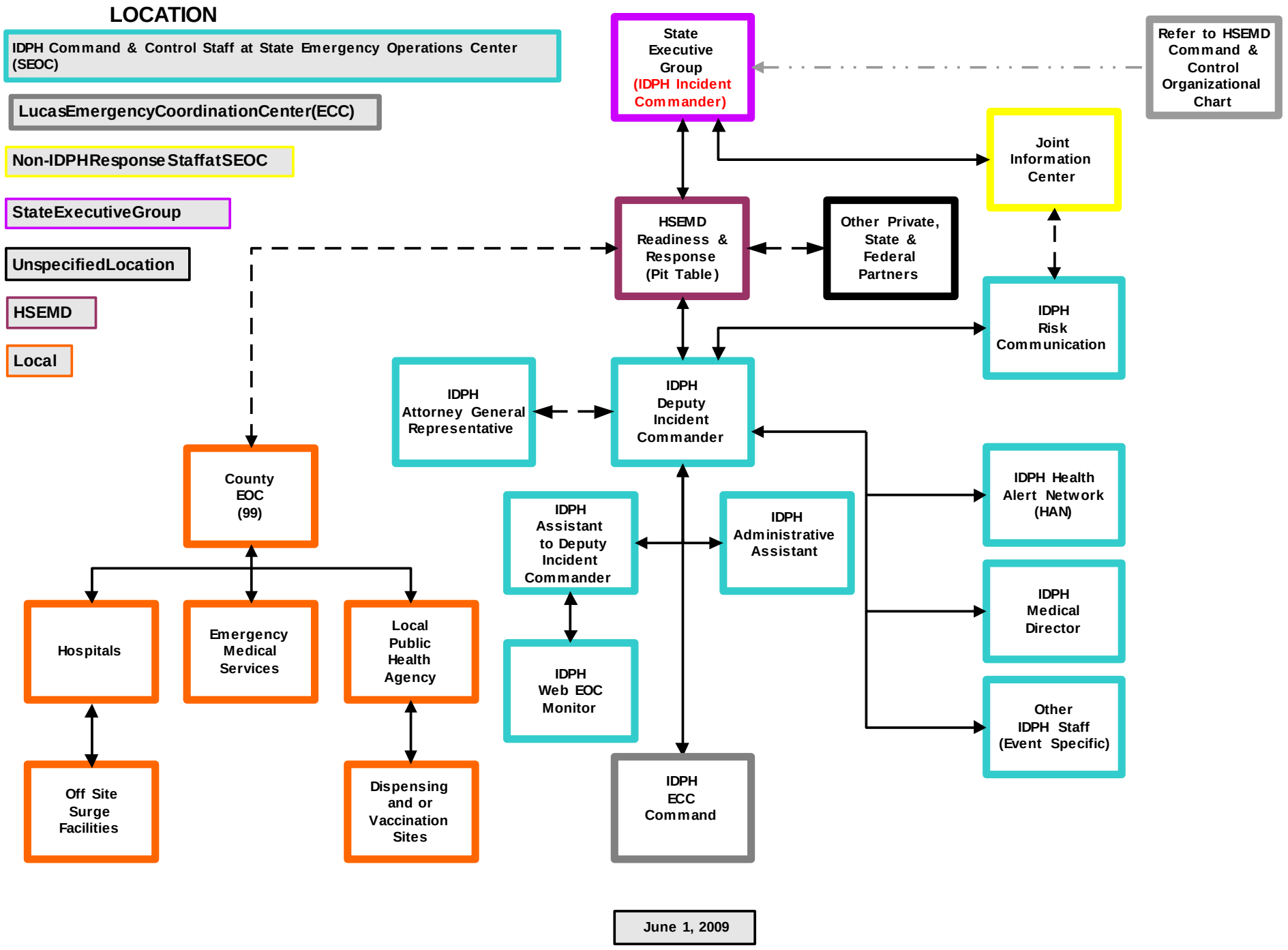

Rebecca Curtiss
Bureau Chief
Linda Pike
AA2
Joe Ferrell
EO2
Kari Catron
PP3
Education
&
Exercise
EMS
Certification
Coalitions
EMS
Training
Centers
EMS
Education
State
Exercise
Providers
Single
County
Multiple
County
State
Committees
Providers
Services
Medical
Directors
Coverdell
Development
AAR/IP
Updated 8-6-14


Rebecca Curtiss
Bureau Chief
Terry Smith
MA3
Marty Smith
PP2
Clark Christensen
EOZ
Tom Boeckmann
PP3
Technology Programs
Warehousing
Pharmaceuticals
Medical Reserve Corps
Public Health Response Teams
Response Equipment & Supplies
Iowa Health Alert Network
Iowa Statewide Emergency Registry of Volunteers
EMResources
System Registry
EMS Data Trauma Registry
Patient Tracking (Future)
General Warehouse
Antiviral Warehouse
Antivirals
Chempack
State Coordinator
16 Local MRC Units
Disaster Medical Assistance Team
Environmental Health Response Team
Logistical Support Response Team
Iowa Mortuary Operational Response Team
Trucks & Trailers
Mobile Health Care Facility
Communications
Other Resources
Updated 10-2-14

Attachment 68

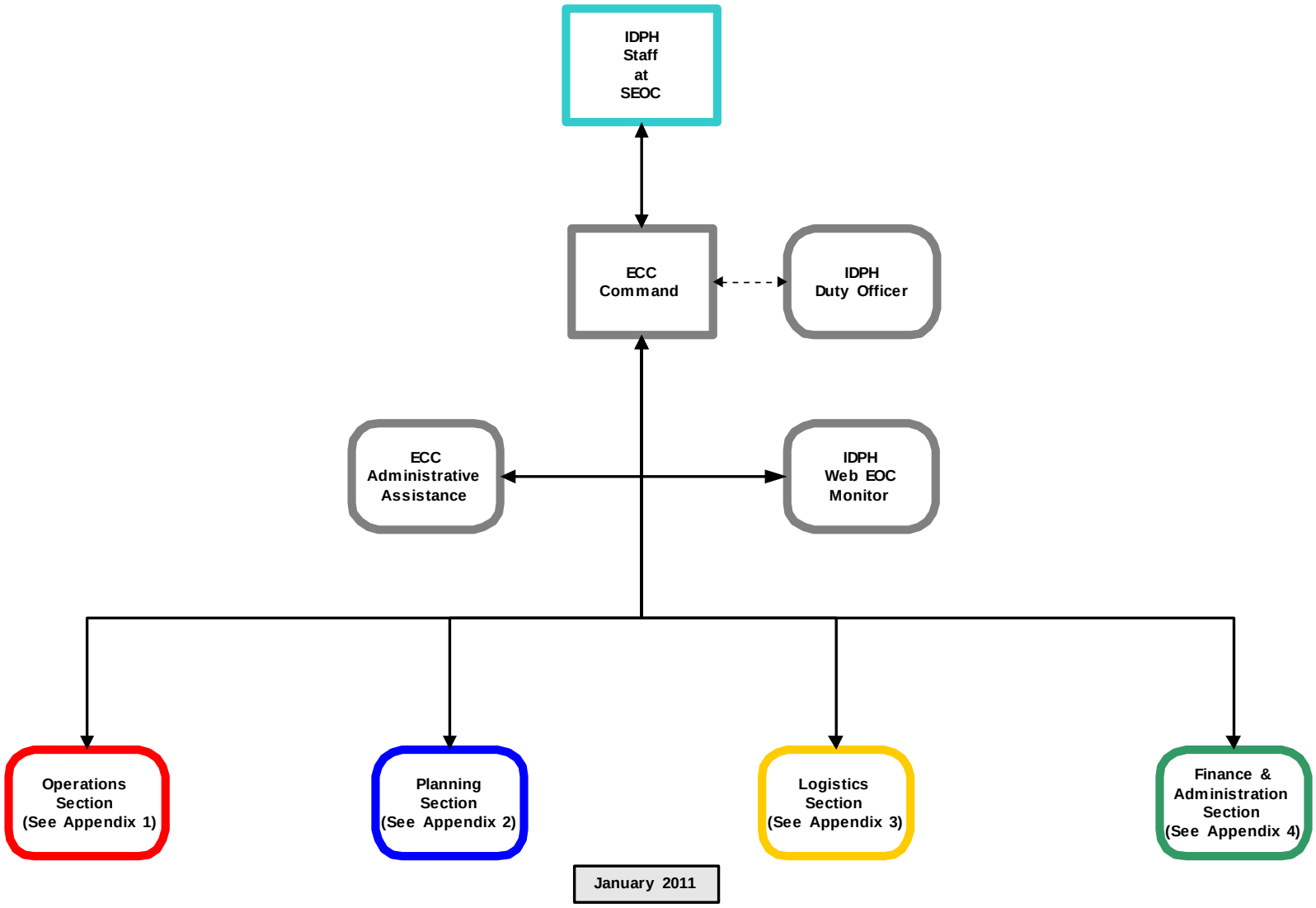
Incident Management System Organizational Charts

IDPH Incident Management Structure-*Command and Control*



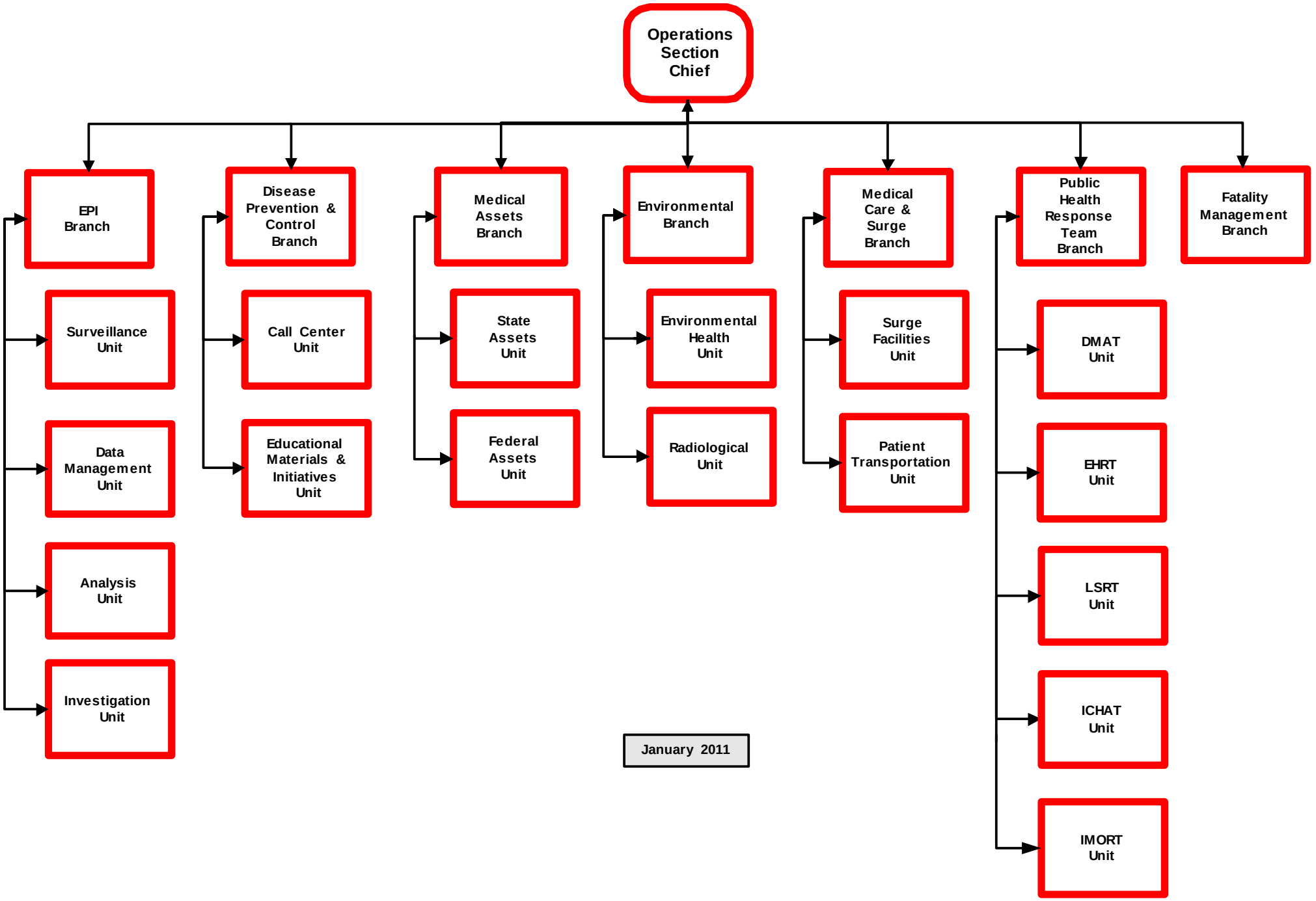
IDPH Incident Management Structure

Emergency Coordination Center - ECC



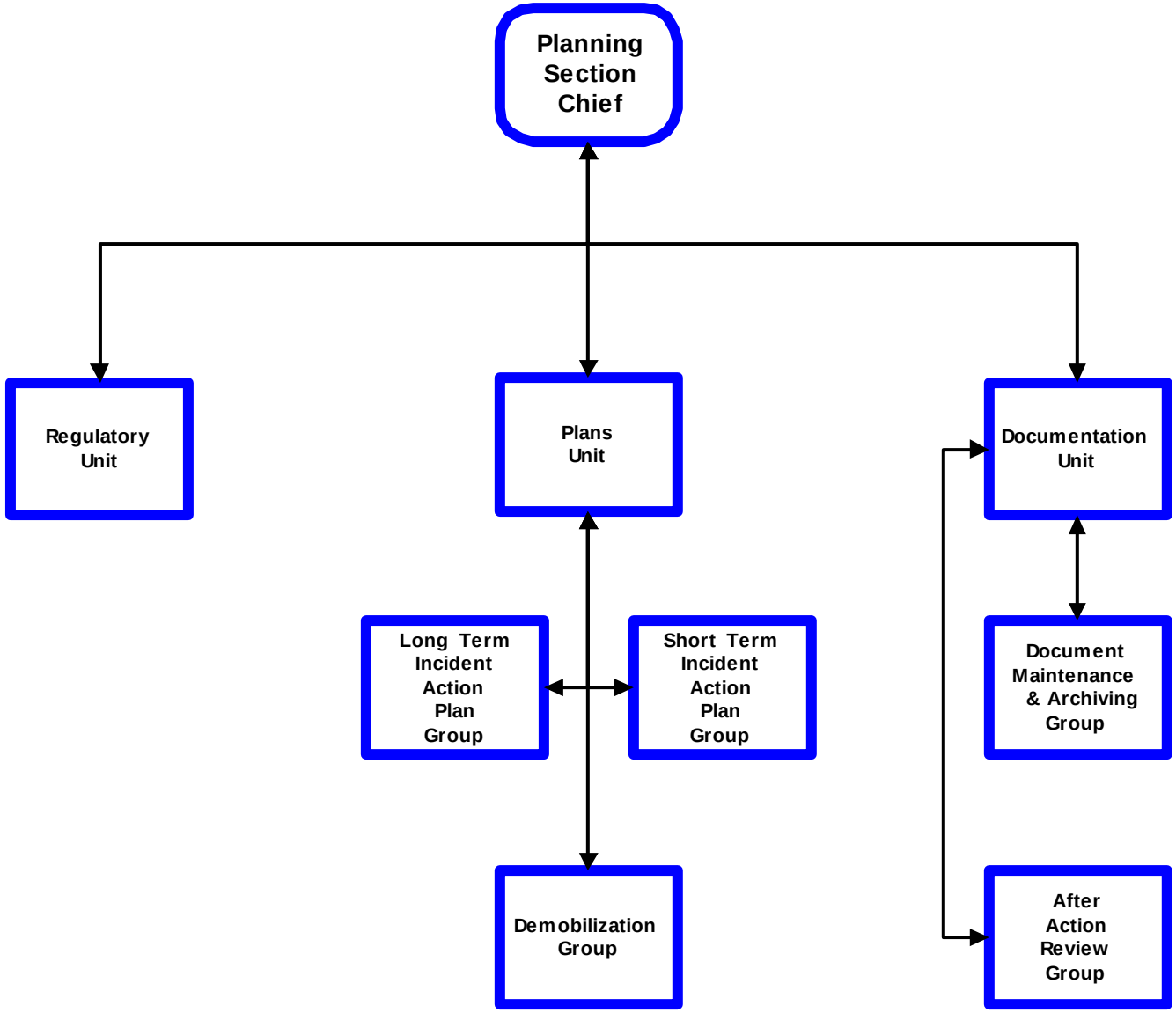
IDPH Incident Management Structure-*Operations Section*

Appendix 1



IDPH Incident Management Structure-*Planning Section*

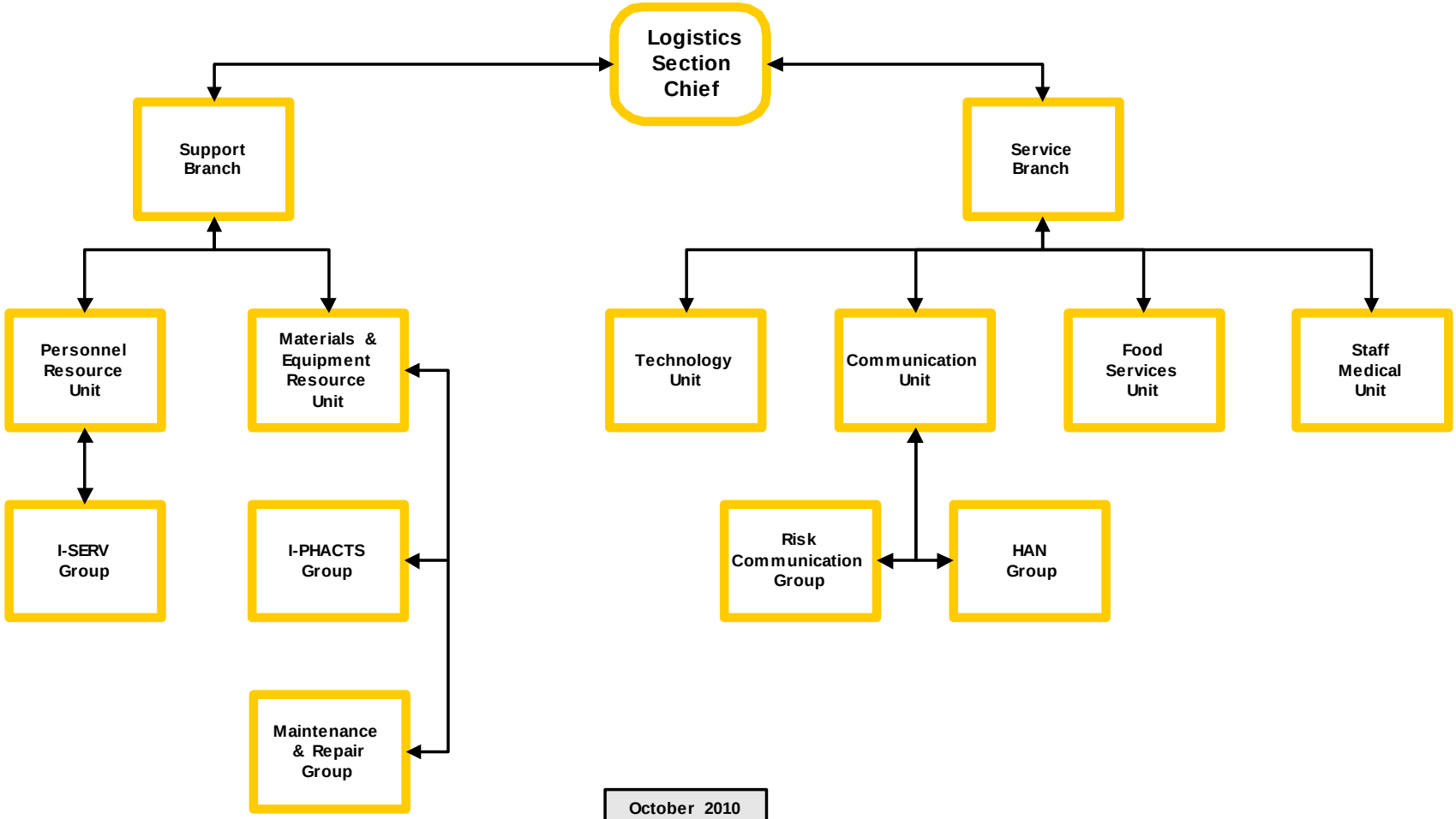
Appendix 2



June 1, 2009

IDPH Incident Management Structure-*Logistics Section*

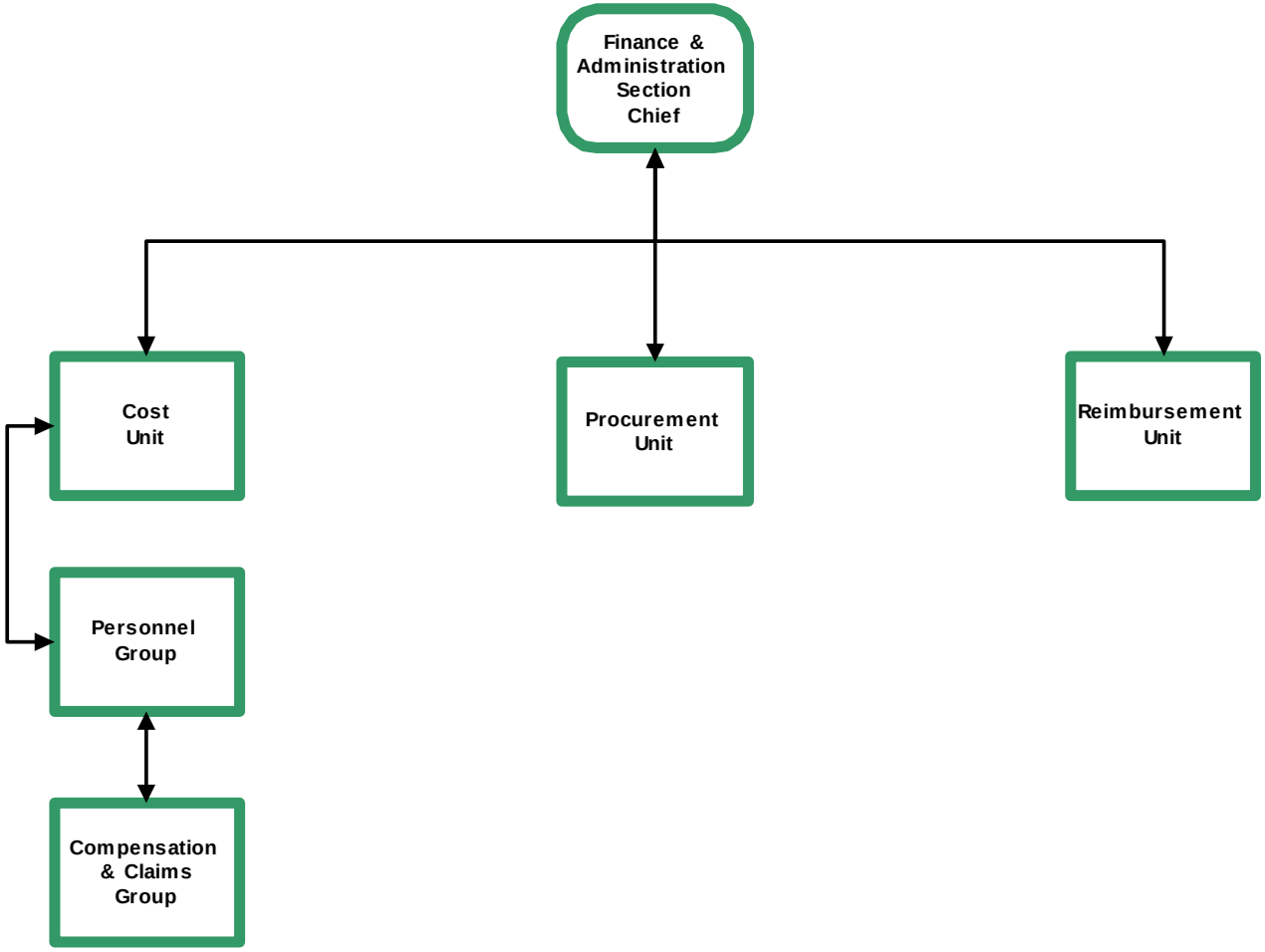
Appendix 3



October 2010

IDPH Incident Management Structure-*Finance & Administration Section*

Appendix 4



June 1, 2009

Attachment 70

Training Program Self-Assessment Application

Iowa Department of Public Health
Bureau of Emergency and Trauma Services

Iowa EMS Training Program Self-Assessment Application

January 2015

IOWA EMERGENCY MEDICAL SERVICES (EMS) TRAINING PROGRAM SELF-ASSESSMENT APPLICATION

This self-assessment application shall be completed by all institutions seeking approval to operate as an approved Iowa EMS Training Program. This self-assessment application applies to both initial applicants and renewal applicants to conduct primary and/or approval of EMS continuing education. If this is an initial application, a completed needs assessment must accompany this document.

Please complete this self-assessment application and return **one print copy at least 60 days prior** to the scheduled on-site visitation to:

Joe Ferrell
Iowa Department of Public Health
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50309

Information supplied within this self-assessment application will become the property of the Iowa Department of Public Health, Bureau of Emergency and Trauma Services. Institutions making application may wish to make a copy of the completed application and self-assessment prior to returning it to the IDPH, Bureau of Emergency and Trauma Services.

Questions regarding this document may be addressed to Joe Ferrell, IDPH, Bureau of Emergency and Trauma Services.

Completion of this self-assessment application in and by itself does not constitute approval to conduct EMS education by the Iowa Department of Public Health, Bureau of Emergency and Trauma Services.

Approval to conduct EMS education within Iowa will be based on the following:

- Completion of the self-assessment application
- Completion of a needs assessment if applying as a new training program
- On-site survey by verification team
- Recommendation for approval from verification team
- Certification as an Iowa EMS Training Program awarded by the IDPH, Bureau of Emergency and Trauma Services

Approval as an Iowa EMS Training Program shall not exceed a five-year period [IAC 641--131.5(10)i].

GENERAL INFORMATION

Training Program Name

Street Address

Mailing Address (if different from above)

City and State

Zip Code

Indicate the type(s) of institution making application and provide verification

- ☐ NCA Iowa College
- ☐ Iowa Licensed Hospital
- ☐ CAAHEP Approved

Check the appropriate box to indicate initial or renewal application

- ☐ Initial Application
- ☐ Renewal Application

Check the appropriate box(es) below to indicate what level(s) of EMS training that will be provided

Training:

- ☐ Initial Education
- ☐ Approval of EMS Continuing Education

Education Program(s) Offered:

- ☐ Emergency Medical Responder
- ☐ Emergency Medical Technician
- ☐ Advanced Emergency Medical Technician
- ☐ Paramedic

TRAINING PROGRAM DIRECTOR

Last Name _____ First Name _____

Mailing Address _____

City and State _____ Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____

E-mail Address _____ Fax Number _____

Is the training program director certified as an Iowa EMS Provider?

☐ Yes ☐ No

Is the training program director endorsed as an Iowa EMS-Instructor?

☐ Yes ☐ No

Has this training program ever received a letter of concern, a letter of citation, or had its approval or renewal denied, suspended, revoked, or been placed on probation in this or any other state?

☐ No

☐ Yes (please attach a letter of explanation and a copy of the disciplinary action and training program resolution)

TRAINING PROGRAM MEDICAL DIRECTOR

Last Name _____ First Name _____

☐ MD ☐ DO

Mailing Address _____

City and State _____ Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____

E-mail Address _____ Fax Number _____

Clinic and/or Hospital Affiliation _____

Specialty Area / Board Certification(s) _____

Iowa License Number: _____

Has the Training Program Medical Director attended the *"Iowa EMS Physician Medical Director's Workshop"* sponsored by the IDPH, Bureau of Emergency and Trauma Services?

☐ Yes (date attended _____) ☐ No

Statement of Affirmation

I hereby affirm and declare that the training program named in this self-assessment application will comply with all applicable requirements of Iowa Code, Chapter 147A and Iowa Administrative Code, Section 641, Chapter 131. I further affirm and declare that the information in this self-assessment application is true and correct. I understand that falsification of information or failure to comply with all applicable requirements may result in the citation and warning, denial, suspension, revocation or probation of the training program's approval by the Iowa Department of Public Health, Bureau of Emergency and Trauma Services.

Signature of Training Program Director	Date
Signature of Training Program Medical Director	Date
Signature of NCA College Dean (if applicable)	Date
Signature of Iowa Licensed Hospital CEO (if applicable)	Date

A. SPONSORSHIP

STANDARD

The sponsoring institution of an Iowa emergency medical services (EMS) training program shall be a North Central Association of Colleges and Schools (NCA) approved Iowa college or an Iowa licensed hospital that is approved by the Iowa Department of Public Health, Bureau of Bureau of Emergency and Trauma Services to conduct emergency medical care training and/or approval of EMS continuing education with adequate resources and dedication to educational endeavors. (641--131)

Provide Documentation Of One Or More Of The Following:

1. Evidence that the training program's sponsoring institution holds current NCA accreditation as an Iowa college with dedicated resources to EMS education.

2. Evidence that the training program's sponsoring institution is an Iowa approved hospital with dedicated resources to EMS education.

3. Evidence that the training program is currently approved by CAAHEP (if applicable).

B. PROGRAM DIRECTOR

STANDARD

It is recommended that the EMS training program have a full-time program director. The program director's primary responsibility is to the EMS educational program and to assure the success of each course offered. In addition to other assigned responsibilities, the program director shall be responsible for the organization, administration, periodic review, continued development, and effectiveness of the educational program. The EMS training program director shall ensure the cooperative involvement of the EMS training program's medical director.

The program director shall have formal academic training and preparation, and hold appropriate Iowa credentials for the courses being taught in the program, or hold comparable Iowa credentials that demonstrate at least equivalent training and preparation.

The program director should also have formal training and prior experience in education related issues, including evaluation, administration, and legislative issues for the prehospital provider.

The program director shall assume ultimate responsibility for the administration of each program including didactic, clinical, and field phases. It is the program director's responsibility to monitor all phases of the program to ensure that the program educational objectives are met. Collaboration between the program director and the program medical director is essential for success and growth.

Provide Documentation Of the Following:

1. Evidence that indicates what percent of time the training program director allocates toward participating with EMS related programs.

2. Evidence of Iowa credentials equivalent to or comparable to the level(s) of program(s) being conducted.

3. Evidence of training and/or experience in education and evaluation (e.g. Iowa EMS-Instructor, EMS-Evaluator).

4. Evidence to support that the training program director is responsible for the following areas within each EMS program:
   A. Organization
   B. Administration
   C. Periodic Review
   D. Continued Development
   E. Effectiveness of the Educational Program

5. Evidence of how the training program director has the authority to administer all phases of the educational program, including components as:
   A. Didactic
   B. Laboratory
   C. Clinical
   D. Field

6. Evidence of how the training program director and sponsoring institution actively solicits and requires the cooperative involvement of the training program medical director in such areas as:
   A. Didactic
   B. Laboratory
   C. Clinical
   D. Field

Attach the following:

- ❑ Curriculum Vitae (CV) for the Training Program Director
- ❑ Job description for the Training Program Director
- ❑ Table of Organization chart(s) (Parent organization & training program)

C. MEDICAL DIRECTOR

STANDARD

The EMS training program shall have an appointed medical director who shall, at a minimum, review the educational content of each program curriculum, evaluate the quality of medical instruction, and supervise delivery by the faculty members. The medical director should routinely review student performance to assure adequate progress toward completion of the program's educational objectives. The medical director must attest that each student has achieved the desired level of competence (didactic, lab, clinical, field) prior to course completion.

The medical director shall be an Iowa licensed physician with experience and current knowledge of emergency care of ill and/or injured patients. This individual must be familiar with base station operation including communication with, and direction of, out-of-hospital emergency units. The medical director must be knowledgeable about EMS educational programs including legislative issues. The medical director shall complete the "Iowa EMS Physician Medical Director's Workshop" *within one year from appointment. The medical director shall be an active member of the local medical community.*

Provide Documentation Of The Following:

1. Evidence of license as an Iowa physician.

2. Evidence of completion of the *"Iowa EMS Physician Medical Director's Workshop"*.

3. Evidence of how the program medical director is appointed and/or selected.

4. Evidence that the medical director actively participates in the local medical community and/or local EMS organization.

5. Evidence of frequency and how the medical director reviews and approves the educational and medical content of the program(s) curriculum.

6. Evidence of frequency and how the medical director reviews and approves the quality of medical instruction by the program faculty.

7. Evidence of frequency and how the medical director reviews and approves the supervision of students by the program's faculty.

8. Evidence of frequency and how the medical director reviews each student's progress and performance.

9. Evidence of frequency and how the medical director assures adequate progression of each student towards the completion of the program's established objectives.

10. Evidence of how the medical director stays current and updated with such issues as base station operations, emergency medical care provider scope of practice, and legislative issues regarding out-of-hospital providers.

Attach the following:

- ❑ Curriculum Vitae (CV) for the Training Program Medical Director
- ❑ Job description for the Training Program Medical Director

Medical Director Information

Name:
How long have you been a serving in the present program with the program?
Have you been a medical director of an ambulance service?

- ☐ Yes, Presently a medical director
- ☐ Yes, Previously a medical director
- ☐ No

If yes, how long have you served as a medical director?
If yes, but now no longer a medical director, what was your last year serving?

	Y	**N**		**Y**	**N**
Advanced Cardiac Life Support Provider			Current?		
Advanced Cardiac Life Support Instructor			Current?		
Advanced Trauma Life Support Provider			Current?		
Advanced Trauma Life Support Instructor					
Pediatric Advanced Life Support Provider					
Pediatric Advanced Life Support Instructor					
Basic Trauma Life Support Provider					
Basic Trauma Life Support Instructor					
Prehospital Trauma Life Support Provider					
Prehospital Trauma Live Support Instructor					
Do you?					
Lecture to students?			Hours		
Participate in lab exercises?			Hours		
Review written exams for content and appropriateness?					
Review practical testing?					
Review clinical performance?					
Review field experience?					
Participate in practical testing?					
Participate in oral testing? (NCS: EMT-P Curriculum)					

Responsibilities:	Y	N
Do you review and approve the educational content of the curriculum to certify its appropriateness and medical accuracy?		
Do you review and approve the quality of medical instruction?		
Do you review and approve the evaluation of students?		
Do you review each student's progress and assist in development or corrective measures for students that do not show adequate progress?		
Do you assure the competence of each graduate of the program in the cognitive, psychomotor and affective domain?		
Do you work cooperatively with the Program Director?		

If any of the questions under "responsibilities" is NO, include narrative identifying who is responsible.

D. INSTRUCTIONAL FACULTY

STANDARD

The faculty shall be qualified through academic preparation, training, and experience to teach and/or evaluate the courses or topics to which they are assigned. At a minimum, each course coordinator, outreach course coordinator, and primary instructor utilized by the training program shall be endorsed as an Iowa EMS-Instructor. Each evaluator utilized during the certifying examination shall be endorsed as an Iowa EMS-Evaluator.

A program shall be able to provide evidence that each instructor and evaluator is thoroughly qualified to instruct or evaluate students in assigned topics. Appropriate expertise in the assigned topic should be assessed prior to initial appointment of the faculty and their ongoing expertise should be monitored throughout the faculty member's tenure.

Provide Documentation Of The Following:

1. Evidence that each course coordinator, outreach course coordinator, and primary instructor is endorsed as an Iowa EMS-Instructor.

2. Evidence that each instructor is qualified through academic preparation, training, and experience to teach the courses or topics to which they are assigned.

3. Evidence that each instructor utilized by the training program is evaluated by the participants of the program on a regular basis.

4. Evidence that each instructor utilized by the training program is evaluated by the training program director and medical director on a regular basis.

5. Evidence that each evaluator utilized by the training program to evaluate the certifying examination is endorsed as an Iowa EMS-Evaluator.

6. Evidence that each evaluator utilized by the training program is evaluated by the training program director and medical director on a regular basis.

Course Coordinators

List all course coordinators utilized by the training program and attach a CV for each individual listed.

Last Name	First Name	Courses Instructed	Certification/License Number

Primary Instructors

List all primary instructors utilized by the training program and attach a CV for each individual listed.

Last Name	First Name	Courses Instructed	Certification/License Number

E. FINANCIAL RESOURCES

STANDARD

The training program shall have adequate financial resources to assure the continued operation of the educational program(s) in which students are enrolled.

The training program's budget shall reflect sound educational priorities including those related to the improvement of the educational process of both students and faculty.

Provide Documentation Of The Following:

1. Evidence that the training program's sponsoring institution will financially support the completion of each program initiated.

2. Evidence that the training program's budget supports sound educational priorities including those related to the improvement of the educational process of both students and faculty.

F. PHYSICAL RESOURCES - FACILITIES

STANDARD

Classrooms, laboratories, and administrative offices shall have sufficient space and design to accommodate the number of students matriculating in the program and the supporting faculty. Facilities shall support an educational environment to include such things as adequate lighting, seating capacity, and temperature control. These standards shall include all off-campus programs.

Provide Documentation Of The Following:

1. Evidence that administrative offices are adequate in size and design to support the number of faculty and administrative staff.

2. Evidence that each classroom/laboratory is adequate in size for the number of students enrolled in the program

3. Evidence that each classroom/laboratory supports and educational environment.

G. PHYSICAL RESOURCES – EQUIPMENT AND SUPPLIES

STANDARD

Sufficient equipment and supplies to be used in the provision of instruction shall be available and consistent with the needs of the curriculum and adequate for the students enrolled. Adequate space and environment shall be provided for the storage of all equipment and supplies. All equipment and supplies shall be in proper working order. A written policy shall be in place that addresses the cleaning, storage, and disposal of all equipment and supplies used in the educational program. These standards shall include all off-campus programs.

Provide Documentation Of The Following:

1. Evidence that equipment and supplies used in the provision of instruction are consistent with the needs of the curriculum and adequate for the students enrolled.

2. Evidence that equipment and supplies are in proper operational order.

3. Evidence that all equipment and supplies are cleaned, stored and disposed of appropriately.

H. PHYSICAL RESOURCES – LEARNING RESOURCES

STANDARD

The current approved curriculum and library resources, related to the curriculum, shall be readily accessible to all enrolled students (on-campus and off-campus) and shall include current EMS and medical periodicals, scientific texts, audiovisual and self-instructional resources, and other appropriate references.

Provide Documentation Of The Following:

1. Evidence that the current curriculum and related educational materials are readily available to all students.

2. List of EMS educational materials available to all students.

I. PHYSICAL RESOURCES – CLINICAL EXPERIENCE

STANDARD

Clinical experiences shall be made available that are consistent with the needs of the curriculum and adequate for the students enrolled. Clinical affiliations that are outside of the sponsoring training program shall be established and confirmed in written affiliation agreements with institutions and/or agencies that provide clinical experience under appropriate medical direction and clinical supervision. A list of approved clinical sites, to include scheduling information and site contact person(s), shall be made available to each student. Students shall have access to patients who present common problems encountered in the delivery of emergency care in adequate numbers and in distribution by pathophysiology, sex, and age. Students shall be assigned in clinical settings where experiences are educationally efficient and effective in achieving the program's stated clinical objectives. Clinical experiences shall include areas such as the operating room, recovery room, intensive care unit, coronary care unit, labor and delivery room, newborn nursery, pediatrics, emergency department, psychiatric unit, long term care facilities, home health care services, and intravenous or phlebotomy team.

Supervision in the clinical setting shall be provided by appropriate program instructors or hospital/agency personnel, such as EMS providers, allied health providers, nurses, or physicians. The ratio of students to instructors in the clinical setting shall be adequate to assure effective learning. All clinical preceptors shall have education in the supervision of EMS students to include, at a minimum, the program's clinical objectives, EMS provider's skills by certification level, and proper documentation of the student's clinical experience. EMS students shall have the opportunity to evaluate their clinical experience and preceptor after each scheduled shift. EMS students shall not be substituted as required team members or staff in the clinical setting.

Provide Documentation Of The Following:

1. Evidence that clinical experiences are available that support the objectives of the curriculum and adequate for the students enrolled.

2. List of clinical resources to include available areas, scheduling, information, and clinical site contact person(s).

3. Evidence that clinical resources outside of the sponsoring training program are established with written affiliation agreements.

4. Evidence that each clinical site has identified medical direction and clinical supervision.

5. Evidence that clinical preceptors have adequate training to supervise EMS students.

6. Evidence of student clinical objectives.

7. Evidence of student evaluation by clinical preceptors.

8. Evidence of clinical site/preceptor evaluation by student.

9. Evidence of adequate patient contacts by pathophysiology, age, and sex by clinical site.

10. Evidence that EMS students are not substituted as required team members in the clinical setting.

11. Evidence that no student is allowed to participate in the clinical experience after completing the training program's requirements for program completion.

J. PHYSICAL RESOURCES – FIELD EXPERIENCE

STANDARD

The field experience phase of the program provides the student with a progression of increasing patient care responsibilities which proceeds from observational experience, to working as a member of the team, to a team leader role. Field experiences shall be made available that are consistent with the needs of the curriculum and adequate for the students enrolled. Field affiliations that are outside of the sponsoring training program shall be established and confirmed in written affiliation agreements with institutions and/or agencies that provide field experience under appropriate medical direction and field supervision. A list of approved field sites, to include scheduling information and site contact person(s), shall be made available to each student. Students shall have access to patients who present common problems encountered in the delivery of emergency care in adequate numbers and in distribution by pathophysiology, sex, and age. Students shall be assigned in field settings where experiences are educationally efficient and effective in achieving the program's stated field objectives. Enough of the field experience shall occur following the completion of the didactic and clinical phases of the program to assure that by completion of this portion of the program each student will achieve the desired competencies of the curriculum.

Supervision in the field setting shall be provided by approved preceptors who hold certification/license equal to or greater than the level of the program being completed by the student. The ratio of students to preceptor in the field setting shall be adequate to assure effective learning. All field preceptors shall have education in the supervision of EMS students to include, at a minimum, the program's field objectives, EMS provider's skills by certification level, and proper documentation of the student's field experience. EMS students shall have the opportunity to evaluate their field experience and preceptor after each scheduled shift. EMS students shall not be substituted as required team members or staff in the field setting.

Provide Documentation Of The Following:

1. Evidence that field experiences are available that support the needs of the curriculum and adequate for the students enrolled.

2. List of field resources to include level of service provided, scheduling information, and field site contact person(s).

3. Evidence that field resources outside of the sponsoring training program are established with written affiliation agreements.

4. Evidence that each field site has identified medical direction, approved protocols, and field supervision.

5. Evidence that field preceptors have adequate training to supervise EMS students.

6. Evidence of student field objectives.

7. Evidence of student evaluation by field preceptors.

8. Evidence of field site/preceptor evaluation by student.

9. Evidence of adequate patient contacts by pathophysiology, age, and sex by field site.

10. Evidence that EMS students are not substituted as required team members in the field setting.

11. Evidence that no student is allowed to participate in the field experience after completing the training program's requirements for program completion.

K. STUDENTS – ADMISISSION POLICIES AND PROCEDURES

STANDARD

Admission of students shall be made in accordance with clearly defined and published practices of the institution and Iowa Administrative Code 641--131. Specific academic, health related, and/or technical requirements for admission shall also be clearly defined and published. The standards and/or prerequisites must be made known to all potential program applicants. Programs are encouraged to develop objective, success-related admission standards and/or prerequisites.

The program officials shall be responsible for establishing a procedure for determining that the applicants' or students' health will permit them to meet the written technical standards of the program. Students must be informed of and have access to the usual student health care services of the institution. The health and safety of students, faculty, and patients associated with educational activities must be adequately safeguarded.

Accurate information regarding program requirements, tuition and fees, withdrawal/refund policies, pass rates, institutional and program policies, procedures, and supportive services, shall be available to all enrolled students. This information shall be given in written form to all enrolled students no later than the end of the first scheduled class.

There shall be a descriptive synopsis of the functional job analysis and current curriculum on file and available to applicants and enrolled students. There shall be a statement of course objectives, copies of course outlines, class and laboratory schedules, clinical and field experience schedules, and teaching plans on file and available.

Every program should make documents available which clearly and accurately describe the course of instruction and the requirements for graduation and Iowa certification. These materials should also describe all costs to be borne by the student and all services to which the cost entitles the student. Student travel and transportation requirements should be clearly stated.

The training program shall have liability insurance and shall offer liability insurance to all students while enrolled in a training program.

Provide Documentation Of The Following:

1. Evidence that the program has published admission polices and procedures.

2. Evidence that the program's admission policies meet the minimum requirements established by IAC 641--131.

3. Evidence that the program has objective, success-related admission standards and/or prerequisites.

4. Evidence that the program has informed the enrolled students of access to available health care services.

5. Evidence that the program has records of the enrolled students' health status.

6. Evidence that the program has established policies that safeguard the health and safety of students, faculty, and patients.

7. Evidence that the program has disclosed accurate information regarding program entrance requirements, tuition and fees, withdrawal/refund, institutional and programmatic policies, procedures, supportive services, graduation requirements, and pass rates available to each enrolled student.

8. Evidence that the program has a descriptive synopsis of the functional job analysis and current curriculum available to each enrolled student.

9. Evidence that the program has made available, to each enrolled student, the course objectives, course outline, classroom and laboratory schedules, clinical and field objectives and schedules, teaching plans, and requirements for graduation and certification.

10. Evidence that the program has made available to each enrolled student information regarding all fees borne by the student and what services/products are inclusive of the said fees.

11. Evidence that the program has informed each enrolled student information regarding student travel and transportation responsibilities.

12. Evidence that the training program has liability insurance and/or makes liability insurance available to each student enrolled in the program.

L. STUDENTS – IDENTIFICATION

STANDARD

Students shall be clearly identified, at a minimum, in the clinical and/or field setting. This identification shall include student's name, student status, level of program being completed, and the sponsoring training program. Identification may be accomplished by using nameplate, uniform, or other means to distinguish them from other personnel.

Provide Documentation Of The Following:

1. Evidence that each student in the clinical and/or field setting is appropriately identified.

M. STUDENTS – EVALUATION

STANDARD

Evaluation of students shall be conducted on a recurring basis and with sufficient frequency to provide both the student and program faculty with valid and timely indicators of the student's progress and achievement of the competencies and objectives stated within the program's curriculum. The methods used to evaluate students shall be standardized. Evaluation methods, including written evaluations, practical evaluations, and direct assessment of student competencies in patient care environments, shall be appropriate and consistent in design to assure valid assessment of stated competencies and objectives.

In order to assure effectiveness of student evaluation, the test instruments and evaluation methods shall undergo frequent review for validation and reliability. When appropriate, reviews must result in the update, revision, or formulation of more effective test instruments or evaluation methods. The evaluation system shall verify student achievement of stated competencies and objectives. Students shall have ample time to correct identified deficiencies in knowledge and/or performance prior to completion of the program. Identified student deficiencies shall be given to the student in writing along with a plan of correction and/or remediation.

Provide Documentation Of The Following:

1. Evidence that student evaluation is completed frequently enough to assure that both student and program faculty are aware of the student's progress and achievement of the stated program competencies and objectives.

2. Evidence that evaluation instruments and/or methods are standardized and verify stated program competencies and objectives.

3. Evidence that evaluation instruments and/or methods undergo frequent review to assure, at a minimum, validation and reliability.

4. Evidence that students are given documentation of identified deficiencies and a plan of correction and/or remediation.

5. Evidence that the student is allowed adequate time to correct identified deficiencies prior to completion of the program.

6. Evidence that the program's medical director has knowledge of each student's progress and evaluation throughout and prior to completion of the program.

N. STUDENTS – GUIDANCE AND GRIEVANCES

STANDARD

Programs shall have student guidance procedures that include documentation of regular and timely discussions with qualified faculty and/or counselors. Areas of discussion shall include such things as student strengths, weaknesses, and progress within the program. These procedures shall provide evidence that students are informed of fair practices, due process with regard to admission/retention policies, unfavorable evaluations, and disciplinary policies such as those for suspensions and dismissal. Academic counseling services shall be accessible to all enrolled students.

The training program or sponsoring institution shall have a defined and published policy and procedure for processing student and faculty grievances. Each enrolled student and faculty member shall receive this policy and procedure information in written form at the beginning of the program or employment as a faculty member.

Provide Documentation Of The Following:

1. Evidence that the training program has academic guidance counseling services available to all enrolled students.

2. Evidence that the training program or sponsoring institution has an established grievance policy and procedure for both students and faculty members.

3. Evidence that the training program or sponsoring institution has made their grievance policy and procedure available to enrolled student and faculty members.

O. STUDENTS – RECORDS

STANDARD

Satisfactory records shall be maintained for each student enrolled in each program. Records shall include, at a minimum, information regarding achievement of prerequisites, satisfactory completion or lack of completion of training program requirements, academic counseling, health records, formal evaluations, disciplinary actions, and grievances. Student records shall be maintained for a time period to be determined by the training program or sponsoring institution to facilitate research, student assessment, academic transcripts, graduation, and certification success.

Provide Documentation Of The Following:

1. Evidence that student records are maintained for each student enrolled in a program.

2. Evidence that student records are inclusive of minimal information.

3. Evidence that student records are maintained for an established time period to facilitate research, student assessment, academic transcripts, graduation, and certification success.

P. PROGRAM EVAULATION

STANDARD

Program evaluation methods shall emphasize gathering and analyzing data on the effectiveness of the program in developing competencies consistent with the stated program goals and objectives. The program shall periodically review and assess its effectiveness in achieving its stated goals and objectives. The review of measurement techniques and evaluation methods is a necessary component to verify program effectiveness. Appraisal techniques such as task analysis of skills, content validity, test analysis with discrimination and difficulty indices, graduate performance, student comment, and instructor observation are appropriate.

Program personnel shall gather information from as many sources as possible because a single source of data cannot be expected to provide conclusive findings. Documented internal evaluation shall take place with each class. The cumulative results shall be incorporated into the program, as well as into the self-study, site visitation, other approval processes, or reports.

Program evaluation may be accomplished through a variety of methods, such as surveys of current and former students, follow-up studies of graduate employment and credentialing examination performance, and input from the various groups representing the program's communities and their interests. The results of program evaluation shall provide the basis for ongoing planning and appropriate change.

Programs shall have an advisory committee that is comprised of training program representatives, affiliated medical facilities, local medical establishments, transporting, and non-transporting personnel. This advisory committee shall meet with the training program on a frequent basis to assess the program's achievement of stated goals and objectives.

Provide Documentation Of The Following:

1. Evidence that the training program undergoes frequent self-review/assessment.

2. Evidence that the training program utilizes multiple forms of data for self-review/assessment.

3. Evidence that the training program has an established advisory committee that is comprised of appropriate members.

4. Evidence that the training program meets with its advisory committee on a frequent basis.

5. Evidence that the training program surveys, and is aware of, their community's needs.

6. Evidence that the training program evaluates the gathered data and information from their self-review/assessment to facilitate changes within their program(s).

Q. CURRICULUM

STANDARD

Iowa EMS training programs shall utilize, as a minimum, the appropriate curriculum approved by the Iowa Department of Public Health, Bureau of Emergency and Trauma Services *as outlined in IAC 641—131.*

Provide Documentation Of The Following:

1. Evidence that the training program utilizes, the department's approved curriculum within the time frame required.

Program Hours and College Credit

Please indicate the number of hours required by the training program for each level of training offered. Also indicate the number of college credits if offered.

Level of Training	Classroom-Lab Hours	Clinical Hrs/Pt Contacts	Field Hrs/Pt Contacts	College Credit Yes	College Credit No	Credit Hours
EMR						
EMT						
AEMT						
Paramedic						
CCP						

Is college credit being offered by an educational institution other than the training program making application?

○ Yes ○ No

If the answer is yes, what is the name of the institution? _____

R. CONTINUING EDUCATION

STANDARD

All approved Iowa EMS training programs may approve EMS continuing education. All approved EMS continuing education shall meet the requirements as stated in IAC 641--131. It is recommended that each training program survey the community for needed continuing education programs.

Provide Documentation Of The Following:

1. Evidence that the training program approves EMS continuing education in accordance with IAC 641—131.

2. Evidence that the training program maintains continuing records in accordance with IAC 641—131.

3. Evidence that the training program submits continuing education records to the IDPH, Bureau of Emergency and Trauma Services in accordance with IAC IAC 641—131.

4. Evidence that the training program surveys the community for input on needed continuing education programs.

5. Evidence that the training program monitors the continuing education programs they approve to ensure attendance and proper number of CEHs awarded.

6. Evidence that evaluation of approved continuing education programs are being complete by attendees.

7. Evidence that the training program conducts random on-site evaluations of instructors utilized deliver continuing education programs.